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Maintaining well-being within a culture of ableism: The false self, defenses, and the disability identity

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MAINTAINING WELL-BEING WITHIN A CULTURE OF ABLEISM:

THE FALSE SELF, DEFENSES, AND THE DISABILITY IDENTITY

BY

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Abstract

Disabled individuals face rampant discrimination in the form of ableist microaggressions (Kattari, 2019) and healthcare neglect (Komisar et al., 2005; Power & Bartlett, 2019), yet research on the impact of ableism on well-being is lacking. Watermeyer (2012) posits that disabled people employ necessary defensive strategies to cope with the reality of such oppressive confounds, such as Winnicott's False Self (1960)—the artificial persona one consciously or unconsciously employs to protect oneself from social rejection. However, in the only study known to the researcher that assesses the role of the False Self within the disability community, Eichengreen & Hoofien (2017) explore discriminatory experiences that could contribute to developing the False Self without directly naming them as ableist microaggressions. Therefore, the present study examined whether there is an optimal level of the False Self that can aid in well-being in the lives of disabled individuals experiencing ableist microaggressions and navigating their identity as a disabled individual within the disability community. Results from the sample of 329 disabled individuals who rely on Medicaid-funded disability services indicated that higher levels of the False Self produce significantly better well-being outcomes when an individual experiencing frequent ableist microaggressions does not have a strong disability identity. In contrast, the False Self had a significant and negative impact on well-being when an individual experiences a strong disability identity and high levels of ableist microaggressions. This implies that the False Self is only adaptive when one is not living in a social environment where they can integrate disability into their self-concept and experience peer support of the disability community. The implications of these findings and suggestions for future research are discussed.

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Chapter I

Introduction

In recent years, the field of clinical psychology has made rather substantial improvements in its research, education, and formulations of the experience of marginalization in Western society, leading to a more nuanced picture of the complex relationship between oppression and the strategies employed to cope (Campbell, 2011; Prilleltensky, 2003; Sue, 2010). At the intersection of psychology and disability studies emerged a discussion on the defenses that disabled people employ to cope with ableism, or the rampant discrimination against disabled people. While ableism takes many manifestations, the recurrent theme is that an individual must hide or disavow the disabled parts of themselves in order to fit in (Eichengreen et al., 2016; Watermeyer & Swartz, 2008). Therefore, individuals are left to navigate complex social and political environments that are not fully equipped to bear the entirety of the disabled experience, yet, they must somehow still cope and manage in modern society.

Watermeyer (2012) conceptualizes ableism as a violent form of social misattunement that manifests in both the interpersonal and institutional spheres. In the interpersonal realm, microaggressions are comments in everyday social interactions that communicate derogatory or negative insults about one’s minority status (Kattari, 2019). Ableist microaggressions are messages that disabled people are abnormal, burdensome, difficult, pitiable, less human, or that disability itself is something to be eradicated (ibid). Experiencing this form of discrimination has been linked to disabled individuals having poorer academic performances (Lett et al., 2020) and mental health outcomes (Kattari, 2020), as well as an increased desire to hide one's disability and appear "not different" (Eisenman et al., 2020).

Meanwhile, on a systemic level, disabled individuals experience incredibly high rates of unemployment, inequity in the work force, physical inaccessibility, and a biased healthcare system (Nario-Redmond, 2020). A critical manifestation of institutional ableism is the oppressive healthcare policies that render home care services from government funded programs insufficient (Komisar et al., 2005; Power & Bartlett, 2019), at whim to frequent budget cuts (Heller et al., 2017; Henry et al., 2011; Komisar et al., 2005) and often based on arbitrary standards of what constitutes disability (Nishida, 2015). Healthcare neglect in disabled populations has serious consequences, as a lack of homecare prevents one's ability to shower, dress, eat, or care for their body in the privacy of their own home (Ryan, 2019). However, to date, there are no measures known to the researcher exploring the experience or impact of institutional ableism.

The negative ramifications of such extreme marginalization are profound. While the experience of interpersonal ableism leaves disabled people feeling as though they are tolerated socially only when they work to "overcome" or dim their disabled experiences (Eichengreen et al., 2016; Watermeyer & Swartz, 2008), they learn from the healthcare system that they will only receive care if they fit a narrow and dramatized view of disability (Nishida, 2015). This leaves disabled people navigating two very different self-states, both of which are necessary for their survival, but neither authentic self-expressions.

Highlighting that ableism is a form of social misattunement, Watermeyer (2012) argues that a disabled individual enduring frequent ableism may experience what

Winnicott (1960) coined the False Self. The False Self develops in an individual who experiences frequent early life misattunements with parental figures, and thus internalizes from their social environments that a part of themselves cannot be tolerated by others. Therefore, they may protect themselves from continued rejection by presenting in ways that are palatable to others but neglectful of their true desires and self-expression (Kernutt, 2007). The False Self is explored in contemporary research as low levels of self-relatedness (awareness of emotions, levels of detachment, and spontaneity of expression) and higher levels of environment-directedness (compliance to others, sensitivity to others mirroring, and a need for approval) (Eichengreen & Hoofien, 2017).

Even though the idea of having to disavow or hide the true extent of one's disability to manage ableism in the environment renders similar to the idea of the False Self, there is only one empirical study known to the researcher investigating this intersection. A recent study by Eichengreen and colleagues (2016) assessed the False Self in a sample of deaf/hard of hearing university students by centering how cultural perspectives of disability impact a disabled person's development of the False Self. They found that those with less social integration, those who have internalized their disability as an impairment to overcome, and those who were put in intensive rehabilitation programs designed to eradicate their disability exhibited greater False Self tendencies. While these are critical findings, the authors did not specifically explore or name these factors as byproducts of ableist values and ideals.

There exists debate in the field on how to classify the False Self. It has traditionally been explored as a pathology that the individual should work through in order to live a full life, as it impacts emotional intimacy and causes one to withhold true thoughts and self-expression (Weir & Jose, 2010; Winnicott, 1960). Yet, more contemporary work acknowledges the False Self as a complex (and often advantageous) defensive strategy for social environments that are not yet emotionally sophisticated enough to create a sustainable environment for marginalized people to be fully held, known, or expressed authentically (Bojarski & Qayyum, 2018). This exploration of the False Self sounds akin to defense mechanisms—the unconscious protective strategies that guard one from painful realities and emotions in order to maintain psychological equilibrium (Cramer, 2000). Defenses are critical ways of navigating nonadaptive social environments and are generally understood as existing on a hierarchy of immature to mature (Metzger, 2014). Watermeyer (2012) argues that even though the False Self involves masking affective experiences, it is a rather adaptive defensive strategy for disabled individuals who are continually stuck in social environments that are not equipped to support them. If disabled individuals do not engage in any False Self behaviors, they are exposed to constant social rejection; if they employ too much of the False Self, however, they lose themselves entirely (ibid). Therefore, as with any defense, there is an ideal level of defensive functioning to navigate the reality of stressful environments (Gori et al., 2020). Yet, to date, there are no empirical studies that explore the False Self as a defensive strategy to extreme marginalization that can develop across the lifespan.

Considering the complex relationship among disavowing one’s disability, ableism, and the False Self, the disability identity holds a critical stake in this body of work. Disability identity development is defined as the extent to which one has their disability interwoven in their identity—encompassing their internal beliefs about disability, their ability to tap into the frustration with ableism, and their sense of connection to the disability community (Forber-Pratt et al., 2020a). Research has shown that coherently integrating disability into one's identity helps individuals adapt, navigate social stressors, and keep intact psychological health (Forber-Pratt et al., 2017), whereas difficulties in disabled identity achievement have been associated with a reluctance to disclose disability and ask for needed support accommodations (Penick & Myers, 2019). However, no studies have assessed the disability identity alongside the False Self.

The present study explored the False Self as a potentially adaptive reaction to a culture of ableism. Firstly, it addressed the conceptual confusion around the False Self in empirical literature by exploring its potential role as a defense. Secondly, it addressed the gap in literature on the role of marginalization and ableism in the function of the False Self. Thirdly, it explored to what degree the False Self moderates the relationship between ableism and well-being, as well as to what degree disability identity is a potential protective factor. To do so, this study first explored the False Self as an adaptive defensive strategy that disabled individuals employ to cope with the reality of ableism by correlating it with defense mechanisms. It assessed whether those reporting high levels of ableism also experience lower levels of well-being when the False Self is either too high or low, to highlight the adaptive nature of the False Self in this context. Exploratory analyses explored how to measure and operationalize institutional ableism, as well as assess its impact on this population.

CHAPTER II

Literature Review

The following literature review explores the complexities of interpersonal and institutional ableism to contextualize how Winnicott’s (1960) concept of the False Self could develop in disabled lives. The construct of the False Self—the artificial persona one consciously or unconsciously employs to protect oneself from social rejection—has been used in the field of psychology to conceptualize how marginalized individuals experience their sense of self living within oppressive societies. For example, the concept of the False Self has been explored in LGBTQ+ youth who are taught their true sexual or gender identities are too different or dangerous (Bojarski & Qayyum, 2018), not only by the larger dominant culture but often also within family units, since parents may not share the same identity (Glassgold & Iasenza, 2000). The False Self has also been conceptualized as the lens through which Black men who experience intense racial profiling navigate dominant cultures (Aymer, 2010). The common reactions Aymer (2010) describes to this experience includes “cool posing,” or the experience of controlling one’s speech, manner of dress, movement, and interpersonal dynamics to mask stereotypical attitudes and protect oneself from further social pain. In both of these contexts, the False Self emerges when social justice is denied for marginalized individuals and communities. Similar discussion occurs at the intersection of disability studies and psychoanalysis, highlighting the complex interplay among oppression, ableism, and the adaptive defenses that disabled people craft to cope with these realities (Watermeyer, 2012).

Ableism, the name for discrimination against disabled people, encompasses a wide range of social dynamics and institutional barriers stemming from the assumption that able-bodiedness and able-mindedness are the standard, which causes the needs of disabled people to become secondary (Campbell, 2009; Chouinard, 1997). While the field of disability studies engages in nuanced conversations about what precisely constitutes ableism, it is generally understood as the unwavering social conviction that equality is owed to those with some level of sameness, resulting in deviant bodies sequestered to the periphery of society and forced to experience intense devaluation (Campbell, 2009). Ableism can manifest as inaccessibility, segregation, institutionalization, higher rates of poverty, or microaggressions that impact psychological health (Nario-Redmond, 2019), all of which undermine psycho-emotional well-being (Thomas, 2007). Alternative descriptions of ableism highlight that it is the belief that impairments are inherently horrible, and therefore, the problems disabled people face fall entirely on themselves and their bodies (Amundson & Taira, 2005; Thomas, 2007). Disability being viewed as inherently bad is a critical facet of ableism, as it dictates that disabled bodies must internalize the weight and shame of deviance and are to be “fixed” instead of embraced. The False Self, in its simplest form, is hiding oneself in reaction to a culture of nonacceptance and rejection.

Ableism encompasses a wide range of institutional, interpersonal, and intrapsychic factors, all of which are bidirectional. The nonacceptance of disability in modern society can be seen on an institutional level, as disabled people face inequitable access to education, employment, and proper healthcare. Among disabled people 25 or older, 25% hold a four-year college degree and 35% are actively employed (Nario-

Redmond, 2019), compared to 42% and 65% for non-disabled people (U.S. Census Bureau, 2019). This education and employment disparity can be explained, at least in part, by interpersonal discrimination in academic and occupational settings, and by government policies that restrict disabled people with government-funded healthcare from working or force them into institutionalized care. For example, in New York, over 18,000 disabled people aged 18-64 live in nursing homes as of 2018 (ADA-PARC, 2020). Micro (interpersonal) and macro (institutional) manifestations of oppression inform each other and are bidirectional (Pettigrew, 1997), implying that there can be causal effects either way between intrapsychic processes and institutional systems. Considering a significant form of ableism manifests as physical inaccessibility and institutional barriers, the physical environment reciprocally influences the social, political, and economic barriers, including the social perceptions of disabled people (Bricout & Gray, 2006), and thus greatly impacts how disabled individuals learn to navigate these stressors.

This literature review contextualizes ableism as social misattunement and explores examples of interpersonal and institutional ableism to understand the ways disabled people manage, navigate, and live within these complex social dynamics. This includes exploration of the False Self, well-being, and the disability identity.

Ableism as Social Misattunement

The following section unpacks Watermeyer's (2012) conceptualization of ableism as a form of social misattunement in order to provide context for later exploration of the micro and macro forms of ableism. In addition, we explore ableism specifically through the lens of misattunement to contextualize its underpinnings in the development of the

False Self in an individual, as Winnicott (1960) defines the False Self as a reaction to such misattunement. To understand the psychological underpinnings and impact of ableism, we must conceptualize the root of ableism as the public's difficulty in *holding disabled people in mind*. The inability to think about disability as something other than a form of deviance that should be eradicated has a lasting impact on the disabled person's sense of self and the ways they learn to relate to the world.

Psychoanalytic theorists conceptualized discrimination as the tendency for those in positions of social dominance to assign to those they oppress whatever it is in themselves that they wish to disown and separate themselves from (Cherkin, 1983; Shakespeare, 1994). A general understanding of projection is therefore critical to grasp the intricacies of various forms of oppression. Projection is the process by which certain disavowed aspects or wishes of oneself are imagined to be located within others. This functions as a way to avoid confronting certain uncomfortable truths or anxieties about the self (Goodley, 2014). Disability is an experience that most people will encounter at some point in their lives, which can be anxiety-provoking for non-disabled people to acknowledge. In turn, non-disabled people's discomfort with being dependent, unacceptable, burdensome, unlovable, or ugly is projected onto disabled people in an attempt to disown these feelings and realities in themselves (Watermeyer & Swartz, 2008). Disability invokes a primal fear in most individuals, resulting in disabled people being viewed as objects of fear, pity, disgust, and an acute threat to the American value of one's ability to conquer all (Shakespeare, 1994). This illusion of disabled people being "other" can function as an unconscious way to ward off the existential dread of mortality and bodily fragility that exists in humans cross-culturally (Watermeyer & Swartz, 2008).

Disabled people become the “dustbin for that disavowal” (Hevey, 1991, p. 34), left to carry the burden of affects and anxieties that the rest of society has not yet been able to manage in themselves. This process is the undercurrent of the oppressive control and deprivation that disabled people experience, and it has dramatic consequences (Watermeyer & Swartz, 2008). In classic cases of projection, the disavowed parts of oneself are projected onto other people in order for the individual to symbolically “kill them off” in themselves by subjecting the other person containing the projections to a life of deprivation (Frosh, 1989). This functions as a way for the one projecting to feel whole, but it is typically an unconscious process. This dynamic appears concretely in the high rates of institutional ableism in America, where governmental policies and social environments are geared toward keeping disabled people inferior and on the outskirts of society—as captured, for example, in the higher rates of institutionalization for disabled people in nursing homes and prisons (ADA-PARC, 2020). In this context, we can understand ableism as a byproduct of non-disabled people not *holding disabled people in mind* but instead symbolically killing them off, excluding them, or using them to contain projections.

Being held in the mind of another is a critical facet of attunement: the “performance of behaviors that express the quality of feeling of a shared affect state without imitating the exact behavioral expression of the inner state” (Stern, 1985, p. 142). Feeling attunement from another person means that one’s mental states are seen, understood, and held in the mind of another person (Allen & Fonagy, 2006; Kernutt, 2007). Attunement is an intersubjective process in this context; it is an emotionally and cognitively rich experience between people that typically encompasses positive attachments and a sense of closeness to others (di Maria Nankervis et al., 2013).

While psychotherapy literature acknowledges a therapist's enactment of racism in the therapeutic space as an act of misattunement to their client (Lee et al., 2018), empirical literature that conceptualizes discrimination as a form of misattunement outside this area of research is lacking. Yet, psychotherapy researchers argue that discrimination disrupts the attunement process by leaving the marginalized person internalizing the message that they do not belong (Sue et al., 2008). Considering psychotherapy is a microcosm of interpersonal interactions (Whaley, 2001), this process can be understood as existing on a larger scale in a marginalized person's life and infiltrating all interactions, not just with a therapist. Watermeyer (2012) conceptualized ableism as a form of misattunement not only from those in immediate social circles, but also from society at large. Arguing that the experience of disability is marked with misattunements from an anxious and hostile social environment, Watermeyer (2012) acknowledged that this form of ableism can aggravate and trigger already existing experiences of rejection and misattunement from parental or other interpersonal dynamics.

The idea of misattunement is the undercurrent of the False Self. However, there are no empirical studies to date that address social barriers as a form of misattunement that requires individuals to engage in False Self behaviors in order to survive. Therefore, the following study assesses the impact of ableism on the development of personality and defenses in the lives of disabled people, as a form of social misattunement. Moreover, the present study deliberately does so to depathologize and honor disabled individuals' natural reactions to a culture of violent ableism, social misattunement, and governmental neglect.

Interpersonal Ableism: Microaggressions

While some forms of ableism are structured and embedded into social and political systems (Ostiguy et al., 2016), others manifest in everyday microaggressions, which are remarks that communicate hostile, derogatory, or negative insults in an interpersonal context (Kattari, 2019). Subtle, everyday discrimination is more difficult to identify than blatant ableism and protected by plausible deniability, but is still toxic and pervasive (Calder-Dawe et al., 2020). Sue et al. (2010) conceptualized microaggressions into distinct categories of microinsults (insensitive comments), microinvalidations (nullifying thoughts and experiences), microassaults (nonverbal attacks), and institutional microaggressions (larger structures, practices, and policies that discriminate).

Additionally, recent research identified eight categories of ableist microaggressions (Kattari, 2019). These include:

1. Exclusion from the mainstream population.
2. Responses of astonishment from non-disabled others related to myths about disability.
3. Receiving the message from non-disabled others that disability and People with Disabilities [PWDs] are inherently abnormal and undesirable.
4. Receiving the message from non-disabled others that disability and PWDs are burdensome.

5. PWDs’ experience of non-disabled others who assume to “understand” or identify with the experiences of PWDs.
6. Responses of pity and apologies from non-disabled others.
7. Experiences with non-disabled others’ odd or awkward avoidance behavior.
8. Experiences with intrusive behavior of nondisabled others who assume PWDs need assistance or lack ability (Kattari, 2019).

The Ableist Microaggressions Scale (AMS; Conover et al., 2017) was created as a self-report measure used in research to hone four critical themes of interpersonal ableism. Questions on the AMS assess to what extent the individual interacts with others who: (1) Believe the disabled individual is helplessness; (2) Minimize their disability or accommodation needs; (3) Deny their personhood; and (4) Otherize them.

Nevertheless, the thread linking the various types of ableist microaggressions is the insidious idea that disabled individuals deserve to exist on the outskirts of society. This is often expressed as concrete behaviors while interacting with disabled people, which could include intrusive questions about one’s body, offers of unsolicited help, assumptions of the normal-abnormal binary, assumptions that disabilities are easily visual, and more (Calder-Dawe et al., 2020).

Disabled individuals, in turn, recognize a disconnect between their sense of self and how the public conceptualizes their experience, leaving disabled individuals often feeling misunderstood by those in their immediate social environments. This can lead to a decline in academic performance (Lett et al., 2020), decrease in mental health outcomes

(Kattari, 2020), or feelings of institutional betrayal (Bell, 2018). Eisenman et al. (2020) found that institutional and interpersonal microaggressions on college campuses against people with intellectual disabilities are linked to a decrease in their sense of belonging to their university. These researchers also found that students who reported experiencing microaggressions did not have a strong sense of their disability being interwoven into their identity, but instead wanted recognition as *not different* from their non-disabled peers. These researchers used audio-recorded interviews with nine participants to assess their experience with microaggressions, which they operationalized as moments in which the students felt “misunderstood, disrespected, insulted, or excluded in relation to their identity as a student with an intellectual disability” (Eisenman et al., 2020, p. 6).

Eisenman et al. (2020) found that greater experiences of microaggressions were related to a greater desire to hide one’s disability. This is a pervasive theme in the lives of disabled people, as it is frequently reinforced by societal messages that glorify achieving able-bodiedness. As an example, parents of disabled children often collude with this reaction to ableism by looking for ways to make their child appear less disabled in an attempt to pacify others (McKeever & Miller, 2004). While this conceptually sounds similar to the False Self (e.g., an individual learning that there is a part of themselves to disavow or hide because others are not able to embrace it entirely), it is not directly addressed as such.

There are several limitations of Eisenman et al.’s (2020) study to be considered. Since this study occurred on college campuses and focused on students with intellectual disabilities, research is needed to broaden the scope of this population beyond disabled people receiving higher education. Additionally, the qualitative nature of the study and small sample size meant that there were no hypotheses tested empirically. Instead, the authors identified themes in participants’ stories, generating hypotheses that now need further investigation. Lastly, although one of the most ubiquitous disability microaggressions—that a part of oneself must be modified in order to gain acceptance—has significant thematic connection to the False Self, this concept was not directly addressed as an ableist microaggression. Considering the dearth of research on the topic, a specific aim of the current project was to further investigate the psychological and interpersonal strategies disabled individuals employ to navigate such microaggressions.

The experience of oppression or discrimination overall has been linked to lower levels of well-being, regardless of the intensity or frequency of perpetrations (Sojo et al., 2016; Sue et al., 2019). Ableism, specifically, has been linked to lower levels of health and well-being (HWB; Branco et al., 2019). In Branco and colleagues’ (2019) study, HWB was conceptualized as one’s self-rated happiness, satisfaction with life, and health using three face valid questions. As a broader measure of well-being that includes health, it may not be an accurate representation of psychological well-being, since disability often includes chronic health issues that could be looked at irrespective of psychological well-being. Studies that used scales that focus more comprehensively on psychological well-being, such as the Scales of Psychological Well-Being (SPWB; Ryff & Keyes, 1995), generally focused more on the effectiveness of psychotherapy in improving well-being in disabled populations, including those with multiple sclerosis (Hart et al., 2005) or those with a physical disability, defined broadly (Zemestani & Mozaffari, 2020). No studies known to the researcher utilized this scale in a broader sample of disabled people to assess the impact of ableist microaggressions, which is an area of research that the present study aimed to expand.

Institutional Ableism: Unmet Needs and Government Austerity

While the impact and conceptualization of interpersonal ableism has been well-established in the literature, less research exists on the various forms and differential effects of institutional ableism. It is critical to explore, however, because although the False Self originates in the caregiver relationship, it is reinforced and validated by broader social experiences in medical, educational, and institutional settings (Watermeyer, 2012). To understand the breadth of the disabled experience, we must not only consider their immediate social environments, but also the impact of the larger sociopolitical and governmental policies that trickle down to the interpersonal sphere. As explored through the lens of racism in America, Aymer (2010) reminds us that one's true self is only welcome when social and political systems have the infrastructure and resources to adequately recognize and meet the needs or experiences of those experiencing marginalization. Considering the lack of research on institutional ableism, the present study focused predominantly on interpersonal microaggressions while exploring institutional ableism from the healthcare system as an exploratory variable to address how to quantify this construct for future research. Additionally, as a way to explore the gravity of healthcare discrimination for disabled individuals in the United States, the present study's sample consisted of individuals relying on these healthcare systems for survival.

While there are many forms of institutional ableism, this study focused on ableism within the healthcare system. Institutional ableism occurs when large governmental entities withhold care or services from disabled individuals in such a way that it reiterates the message that society is not prepared or willing to meet their needs. While interpersonal ableism prevents social (and often physical) needs from getting met, institutional ableism reflects this lifelong dependency on insufficient caregivers that exists on a broader scale. With both institutional and interpersonal ableism, the disabled individual is left internalizing the message that they must fit themselves into a particular mold to receive physical and emotional care. In a population in which care needs exist across the lifespan and are often provided by programs and policies regulated by the U.S. government, a profound awareness exists in disabled spaces that the potential for having needs met includes more than just the quality of the relationship with the individual providing such care (Ryan, 2019).

In order to understand the intrapsychic impacts of an insufficient healthcare system, there must be an understanding of how the system is organized. The projected number of disabled Americans that rely on Medicaid for healthcare is approximately 11.4 million (Yang, 2022), as Medicaid remains the main provider for long-term care services that allow disabled people to dress, shower, or eat with the assistance of a personal care attendant. To enroll in New York State Medicaid to receive these services, one must be deemed “disabled” by the definition set forth by the Social Security Administration, which is based not only on one’s disability but the inability to work. The process of proving disability to the government can be arduous, daunting, and shaming, as it often requires compiling multiple invasive medical forms, submitting photographs of oneself, and including bank statements to prove poverty status (Nishida, 2015). To meet the government’s definition of “disabled,” one must continuously prove their financial impoverishment and complete extensive yearly evaluations that leave the disabled person and their family feeling as though they are trying to meet criteria for services often out of reach (Fisher & Goodley, 2007). While there are some federal and state-specific programs that allow disabled individuals to maintain employment after beginning these services, it is not commonplace, and there are still financial criteria to meet in order to maintain eligibility. Disabled people often live in this culture of fear and must align their presentation of disability to fit assessment tools with outdated and arbitrary conceptualizations of the disabled experience (Nishida, 2015). To remain enrolled in these life-saving programs, disabled people have restrictions on how much is allowed in personal bank accounts, how much earned income is allowed, and whether or not one can marry (Lynch, 2019; NY Health Access, 2009). These policies mirror stereotypical and ableist archetypes of disabled people as those that belong on the outskirts of society, not leaving their home to engage in activities, sustain relationships, or manage finances (Davis, 2004). Therefore, disabled individuals navigating these waters carry with them an expectation of misattunement from these systems that, worst case scenario, could result in death if healthcare is denied. There is an overarching awareness that one must actually embody these stereotypical narratives of disability in order to receive healthcare and maintain survival.

This is not a criticism of the need for these resources, nor of the disabled individuals that may meet the criteria set forth by the United States government. When these programs are run properly, they allow disabled people access to the care and resources needed to live in the community. Issues arise out of corrupt policies that keep programs stagnant, defunded, and out of tune with the needs of the disabled people that use them to survive (Ryan, 2019). Moreover, the lack of flexibility in how the government decides who is most deserving of care is the undercurrent of such misattunement and resource guarding. Cuts to Medicaid services for the disabled are commonplace, as those in power often demonize the most marginalized communities so that they become scapegoats for those in power (Ryan, 2019). Under the neoliberal ideology of the individual as responsible for themselves with minimal governmental assistance, governments often enact austerity measures to severely cut healthcare and welfare programs to control debt. When governments engage in these austerity measures and budget cuts, it is often at the expense of the disabled person's ability to engage in basic everyday activities (Power & Bartlett, 2019).

Therefore, one of the most painful realities of this system is that the disabled person must surrender themselves to evaluation and scrutiny with the hope of fitting the definition of disability that will grant them the necessary services (Nishida, 2015). The False Self mimics this intrapsychic paradox, as the individual is left feeling as though only certain versions of themselves will receive care, love, and validation after frequent social misattunements have left them with a fragmented view of themselves (Watermeyer & Swartz, 2008). It's worth noting that this isn't an argument suggesting the individual consciously constructs a false version of themselves to receive services. Rather, it's an exploration of the pervasive intrapsychic conflict experienced by disabled individuals who continually observe and internalize which expression of disability is safest or will fulfill their physical and social needs. While socially expressing disability can lead to rejection, that same expression is almost necessary in order to retain disability services.

These sorts of incongruent social environments become internalized and infiltrate how a disabled person grapples with and constructs their sense of self on an unconscious level.

However, no research exists on the connection among institutional ableism, governmental austerity, and the defenses crafted to navigate such complex social dynamics. Instead, much of the research on government austerity and disability focuses on the negative physical health effects. Disabled people frequently face health issues that can be traced back to harmful insurance policies, and are also at higher risk for barriers in accessing home care (Iezzoni & O'Day, 2006). Research on consumer satisfaction of Medicaid enrollees shows a significant portion of disabled people report unmet needs in home health care services (Heller et al., 2017; Henry et al., 2011), with up to 58% of Medicaid and Medicare enrollees reporting unmet home care needs that frequently result in injuries (Komisar et al., 2005). The United Kingdom is more forthcoming than America in addressing the downfalls of their long-term care programs, reminding us that this culture of deprivation and resource scarcity for the disabled is a worldwide phenomenon (Ryan, 2019). In a sample of disabled people in the U.K., eight out of 10 home care program enrollees were not given enough care hours and had to sleep in their clothes, skip meals, go without showering, or were unable to use the bathroom for up to 14 hours at a time (Ryan, 2019). While this does not address the psychological impact of insufficient care systems, it reiterates the deprivation disabled people are forced into.

Most of the research on the psychological effects of government austerity do not focus on disabled communities. Generally, some studies show rather broadly that governmental austerity appears to substantially increase citizens' rates of suicide, depression, and anxiety (Christodoulou et al., 2016). The five psychological Austerity

Ailments that individuals experience under constant stress and tenuity due to austerity measures are: (1) Humiliation and shame; (2) Fear and distrust; (3) Instability and insecurity; (4) Isolation and loneliness; and (5) entrapment and powerless (McGrath et al., 2016). Yet, there are no studies that address the psychological impact of austerity cuts within communities that utilize home care programs, even though the stakes for lack of access to care are high.

There exists a link between withheld care and subsequent feelings of distrust that emerge from an insufficient healthcare system for disabled individuals (Hepp et al., 2021), as well as healthcare discrimination and distrust among marginalized communities (Cipollina & Sanchez, 2019). Therefore, the present study explored trust in healthcare as a way of addressing one's experience with healthcare discrimination in order to assess the ways in which institutional ableism impacts the disabled individual's defenses, sense of self, and overall well-being. Receiving messages that one must fit a certain mold to receive care and love from some withholding "other" is an area of psychology that has not been explored at the institutional level for disabled individuals. While little research has studied this dynamic, the patterns one is cast into in childhood become a template for later relating to the world and can therefore be reenacted and reaggravated in various systems, relationships, and institutions (Vergunst et al., 2021; Watermeyer, 2012). As an example, the experience of parental neglect or care withheld during childhood can lead to an intense feeling of distrust of others (Hepp et al., 2021).

It is natural for disabled people to not only experience misattunement to their health care needs, but also a deep sense of fear and distrust akin to what many marginalized communities experience under systems or institutions that have historically been sites of oppression and exploitation (Cipollina & Sanchez, 2019). This fear is not only about being overlooked but involves an acute distrust that these services will attune to them enough to allow them to physically care for their body. The research on disability and trust in healthcare has produced contradictory results, and does not explore trust in healthcare as a way to conceptualize one's experience of institutional oppression. While some research shows that non-elderly adults with chronic conditions or disabilities exhibit greater trust in healthcare (Long & Bart, 2007), other studies found that people with a self-reported poor health status report greater distrust (Armstrong et al., 2006; Yang et al., 2011). This discrepancy may be accounted for by the fact that the study reporting greater trust focused on specific questions about whether older adults with conditions trust their doctor to tell them the truth about potential bad news, while the study that reported less trust did not focus on trusting a specific doctor, and did not focus specifically on aging individuals. Overall, the existing research on trust in healthcare in disabled populations encompasses a limited scope that does not include how it impacts one's ability to trust that providers (and the system at large) will meet their needs.

Many next steps are needed that the current study aims to address. First, no measures of awareness of institutional ableism exist, especially in healthcare. Additionally, even though literature identifies that physical neglect causes one to distrust that others will be available to give care (Cloitre et al., 2011), and the fear of care being withheld unless one presents in a certain manner is associated with the intrapsychic experience of the False Self (Winnicott, 1960), no studies meet this intersection. Especially considering the link between distrust that others will meet one's needs and False Self-defenses (Kernutt, 2007), research is needed on the role of a misattuned home healthcare system in the lives of the disabled. Therefore, an important facet of the present study was to explore how the sense of distrust experienced by disabled people is not only a relational distrust of the caretaker themselves, but also one of larger governmental entities that remain elusive yet ever-present.

Overall, due to the ubiquity and intensity of both interpersonal and institutional ableism, it is only natural that disabled individuals form complex protective strategies for navigating these intrapsychic and interpersonal experiences. U.S. society informs disabled people that they must hide or minimize the disabled parts of themselves to fit into the world (Eichengreen et al., 2016; Watermeyer & Swartz, 2008), while social services expect a narrow and archetypal manifestation of disability in order to access physical care (Nishida, 2015). This leaves disabled individuals navigating complex social and political environments that are not fully equipped to bear the disabled experience, resulting in a necessary reliance on learned defenses and strategies to navigate such oppressive climates.

The False Self

Watermeyer (2012) argued that necessary and adaptive defenses exist for navigating intense ableism, drawing parallels between this dynamic and Winnicott's (1960) False Self. Against the backdrop of a larger discussion of ableism, the following section explores the complexities of the False Self in disabled individuals navigating a culture of ableism. Later sections explore how defenses can assist in navigating challenging social climates full of consistent rejection by exploring the False Self as a defense and reaction to oppression. One of the aims of this research is to explore the

False Self as an adaptive defensive strategy to navigating incessant ableism, but also a risk factor for having one's disability as a split-off part of their identity.

The False Self has been explored in psychological theory as a spectrum, an identity, and a defensive strategy, all of which are rich and nuanced conceptualizations of such a complex phenomenon. Overall, recent literature defines the False Self as protecting oneself from continued rejection by presenting in ways that are palatable to others but neglectful of one's true desires and self-expression (Kernutt, 2007).

The False Self has been said to develop in an individual whose early life consisted of parental dynamics of misattunement, or not being adequately held in the mind of their parent (Winnicott, 1960). In other words, the caregiver did not meet the infant's spontaneous gestures, affects, and impulses with mirroring, containment, or attunement, but instead misinterpreted their needs or replaced them with their own (Kernutt, 2007). From these experiences, one learns at a young age that their parent could not survive their true essence, affective experiences, or intense needs, and begins to present in ways that are more palatable to others in order to maintain the necessary bonds with caregivers that their lives depend upon (Newman, 2013). Going into later stages of life, the individual internalizes that there is a part of themselves that cannot be tolerated by others, and that they must alienate from inner self-experiences and develop an acute sensitivity to social demands and other's needs, even at the expense of their own wishes (Eichenreen & Hoofien, 2019). False Self functioning implies the world is viewed as something to be "fitted in" with (Hoggett, 1992, p. 10), which can remain an unconscious ideology embedded in one's psyche.

There exists some debate on how to operationalize the False Self. Some studies and scales have operationalized the False Self as one's conscious formulation of their "true self" and identification of the contexts under which they deviate from it, including the Perceptions of False Self (POFS; Weir & Jose, 2010). Meanwhile, other researchers have defined the False Self as lower levels of self-relatedness and higher levels of environment-directedness (Eichengreen & Hoofien, 2017). Self-relatedness refers to the extent to which one is aware of their needs and feelings, the ability to express oneself spontaneously and authentically, as well as how cohesive one experiences their sense of self. Environment-directedness encompasses how sensitive one is to others' mirroring of their feelings, the extent to which one may rely on others' approval, and to what degree one will comply with the expectations of others at the expense of their own wants. Separating the self-relatedness and environment-directedness subscales allows both aspects of the False Self to be quantified simultaneously, providing a holistic approach to the emotional experience of the False Self and False Self behaviors across a range of contexts, relationships, and settings.

Further debate exists on the factors that contribute to maintenance and development of the False Self. Some contemporary theorists disagree with Winnicott's assertion that False Self develops only in the critical developmental years of youth and infancy, and instead argue that its maintenance and manifestation can develop across the lifespan due to later social influences and experiences (Masterson, 2005; Masterson & Lieberman, 2004). Theorists since Winnicott have shifted the focus from childhood development to explore the False Self as a construct that develops across the lifespan, so long as one exists within nonadaptive social environments that convey messages that one's authentic self cannot be tolerated (Harter & Monsour, 1992; Weir & Jose, 2010). Other theorists, like Watermeyer (2012), argue that, even though the False Self involves masking affective experiences, it can be an adaptive (and therefore unconscious) defensive strategy for marginalized individuals to cope with bigoted social environments throughout the lifespan. Nevertheless, the present study addressed the conceptual confusion of the False Self by exploring its potential role as a defensive strategy for marginalized individuals experiencing discrimination across the lifespan.

In addition to how the False Self is defined, the function and consequences of the False Self are further explored in contemporary literature. Exploring Watermeyer's (2012) conceptualization of the False Self as a defensive strategy for disabled individuals, he argues that masking one's disability or behaving in ways that placate disability can guard against the constant social rejection and inadequate responses of others. However, too much of a False Self can lead to hiding oneself entirely. Therefore, like other defenses, there is an ideal level of functioning to aid in navigating the reality of stressful and hostile social environments (Gori et al., 2020). This conceptualization of the False Self has not yet been explored in empirical literature.

In a similar vein, Winnicott (1960) initially conceptualized the False Self as a continuum from healthy or normative to more pathological presentations. He defined the False Self as a personality organization that exists on a spectrum from healthy to extreme, or from a polite and mannered social attitude to more pathological presentations in which the False Self becomes one's conscious personality. While the present study utilizes Eichengreen and Hoofien's (2017) operationalization of the False Self, Winnicott's (1960) description of a spectrum of the False Self can be used conceptually to understand it as an experience that, like defenses, have an optimal level of functioning to maintain equilibrium. Winnicott's (1960) conceptualization can be summarized as the following:

1. *Extreme:* The False Self becomes one's conscious personality, which can greatly impact emotional intimacy.
2. *Less extreme:* The True Self is acknowledged but kept in a secret life, hidden under the False Self.
3. *More towards health:* The False Self searches for contexts in which the True Self can be safe in being known.
4. *Still further towards health*: The False Self is built on identifications with important objects, such as parents or other caretakers from childhood.
5. *In Health*: The False Self remains a polite and mannered social attitude, where one doesn't "wear their heart on their sleeve."

While we have expanded our conceptualization of the False Self since Winnicott, this framework for thinking about the False Self is useful in centering its role as a defense to ward off anxiety and conflict.

Even with this framework, much of the literature on the False Self highlights its predominantly negative consequences, while leaving out the contexts under which it developed to be an adaptive reaction to unfulfilling social environments across the lifespan. For example, researchers argue that too much reliance on the False Self can alienate one from inner self-experiences, cause acute sensitivity to social demands and others' needs at the expense of one's wishes, lead to a feeling of detachment from the self or others, and cause feelings of emptiness (Eichengreen & Hoofien, 2019). Many of these empirical studies on the False Self highlight its costs in samples of adolescents, focusing on its relationship with lower levels of social support (Harter et al., 1996) and lower levels of security within the family unit (Goldner & Berenshtein-Dagan, 2016).

Most of the empirical literature on the False Self discuss its relationship with negative interpersonal dynamics. For example, Sippola et al. (2007) assessed the False Self in a sample of 501 Canadian adolescents, highlighting the relationship between the False Self and difficulties with interpersonal competency in romantic relationships. Findings indicated that this aspect of the False Self was more likely in those with lower levels of conflict management in friendships as well as those that felt lower levels of confidence in providing emotional support. Meanwhile, Gil-Or et al. (2015) found a link among the False Self, insecure attachment styles, and low self-esteem. While these findings can be useful in understanding the consequences of an over-reliance on the False Self, much of this empirical literature on the False Self focuses on non-disabled adolescents and does not explore if there was any context of marginalization in their lives.

Considering this, many critical pitfalls must be addressed. Further nuanced conceptualization of the function of the False Self is needed in empirical literature. While Watermeyer (2012) argues that the False Self carries the functional purpose of warding off excessive anxiety and consistent social rejection for marginalized populations, most research on the False Self utilizes samples of more privileged, non-disabled participants. Therefore, another aim of the study was to explore the protective nature of the False Self in the lives of disabled individuals. The following section explores the complexities of disability and the False Self in greater depth.

Disability and the False Self

As disability and the False Self are explored, it is critical to not view the False Self as an inherent pathology that accompanies a deformity or disability, or as an internal deficit that the disabled person alone is responsible for unlearning and fixing. Instead, we must understand it as a complex (and sometimes advantageous) response to social environments not yet emotionally sophisticated enough to create a sustainable environment for marginalized people to be fully held, known, and expressed authentically (Bojarski & Qayyum, 2018). At its core, the False Self is behaving in ways or presenting oneself in ways that are more palatable to others in order to maintain necessary social ties for survival. Therefore, the False Self as a reaction to an intense culture of ableism that teaches disabled people there is a part of them that others cannot tolerate unless it is cured, disowned, hated, overcome, or hidden (Watermeyer, 2012) is the framework the present study holds.

The False Self emerges in an alienated individual whose subjugation in modern society has created an entrenched fear of recognition, mostly because being seen by others has led to negative interpersonal experiences (Gabel, 2018). The False Self in disabled people manifests in concrete behaviors and dynamics (Hahn, 1997), ranging from a heightened proficiency in discerning non-verbal body language, taking control of helping behaviors (Gill, 2001), forced artificiality or fake cheerfulness (Sinason, 1992), and pressure to hide disability (Eisenman et al., 2020).

Eichengreen et al. (2016) surveyed a sample of deaf/hard of hearing university students, centering how cultural perspectives on disability impact a disabled person’s development of both the self-relatedness and environment-directedness aspects of the

False Self. They found that lack of social integration with non-disabled peers and the child internalizing the idea that their disability is an impairment are related to the low self-relatedness nature of the False Self. Meanwhile, intensive rehabilitation programs designed to eradicate their disability as well as parents ignoring their child's disability is related to the high environment-directedness aspects of the False Self. These findings reiterate how living with a deviant identity that others overlook out of discomfort and/or think should be eradicated can lead to the embodiment of the False Self, especially if there is a lack of social support and integration from peers.

Eichengreen et al. (2016) found that when a disabled child's parent pushes to eradicate or downplay their child's disability, the child is likelier to use the environment-directedness aspect of the False Self. Considering the push to eradicate, ignore, or downplay disability is a form of ableism (Nario-Redmond, 2019), the overarching theme of ableist microaggressions must be centered in discussing this dynamic. When ableist ideology infiltrates parents of disabled children, it is common for the parent to experience distress in realizing that their child has a disability and even openly declare something is "wrong" with their child (Watermeyer, 2012). The parent can interact with their child in ways that communicate that they wish they were not disabled, which can range from subtle comments to forced surgeries that attempt to eradicate their conditions. The pursuit of normalcy often involves expensive, repeated, and intrusive surgical procedures that are emotionally draining for the recipient, often despite no data on improvements in psychosocial functioning (Parens, 2006). While procedures to alter a child's body to look "less disabled" are often pushed by parents or caregivers in response to their concern about their child's social, occupational, or social lives, acceptance contingent on “blending in” has a profound impact on the child’s relationship with their body and how they learn to receive love from others (ibid.). Eichengreen et al. (2016) supported this conceptualization by finding that False Self development is impacted by parents denying their child’s disability and forcing them into intensive rehabilitation programs to “eradicate” their disability. However, there is not yet empirical research that names this as an experience of ableism. This finding highlights the danger associated with being openly disabled in some contexts, as it is met with immediate rejection and the threat of bodily mutilation. Therefore, research is needed to shift the focus from pathologizing the False Self to understanding its role as a protective reaction to ward off this form of threat and social misattunement.

While ableism and parenting experiences have a critical role in the False Self, the second important finding of Eichengreen et al.’s (2016) study was that when the disabled person has low social integration compared to non-disabled peers or has internalized the message that their disability is an impairment, they are likelier to experience lower levels of the self-relatedness aspect of the False Self. The underpinnings of the False Self in disabled lives go beyond the impact of childhood experiences with parents. The importance of social support from peers in the development of the False Self is well documented (Harter et al., 1996); yet this issue is significantly more complex in the lives of disabled individuals when centering how profoundly ableism impacts one’s capacity to form social support and meaningful friendships.

Considering this, many next steps are needed. Disabled adults need to highlight their disabilities to receive services and have their disability needs met, but the extent to which disability is highlighted can also result in distress when met with social rejection, ableist microaggressions, and the threat of unwanted bodily harm or modification. While Eichengreen et al. (2016) found that the disabled individual experiencing others' viewing disability as an impairment to overcome is related to the development of the False Self in the disabled individual, assessing their conscious awareness of ableist microaggressions was not included in the study. This is a critical next step not only because the push to eradicate disability is a significant facet of ableism, but also because ableism is the backbone of social misattunement and non-mirroring in disabled lives (Watermeyer, 2012).

Similar to a mother not responding adequately to the needs of her child, the inability of social structures to recognize the injustices that thwart marginalized people also produces the False Self (Aymer, 2010). The message that disabled people internalize from a culture of ableism and inaccessibility is that the world is unwilling to recognize or contain them while reminding them that their needs are too much. Therefore, the disabled person internalizes the idea that they must disown a part of themselves to gain social acceptance, love, and care from others. The False Self allows marginalized people to mold themselves into safer personas for the public to protect themselves from the emotional labor of rejection, managing others' discomfort, and experiencing interpersonal violence (Aymer, 2010). Yet, too much of the False Self can leave one feeling as though they have lost themselves entirely. Therefore, research is needed to hone the relationship between openness with one's disability and the False Self.

Defenses

Although defense mechanisms are a critical and ubiquitous aspect of the human experience, no empirical studies known to the researcher consider defenses in how disabled individuals navigate ableism, nor do any empirical studies measure the False Self alongside a scale of defense mechanisms. Similar to Watermeyer’s (2012) conceptualization of the False Self, defense mechanisms generally are unconscious protective strategies that guard an individual against painful realities and emotions to maintain psychological equilibrium (Cramer, 2000). Defense mechanisms protect individuals from experiencing excessive anxiety, guilt, or loss, whether brought on by an external stimulus or some inner psychological state or conflict (Freud, 1936), and are usually unconscious, stable, and enduring characteristics of the individual (Cramer, 1998).

Defense mechanisms carry a critical functional purpose for navigating nonadaptive social environments (Metzger, 2014) and are only considered pathological if they are used with too much intensity or rigidity, are age-inappropriate, or are used in situations where they are no longer needed (Cramer, 1991). Therefore, similar to the False Self, defense mechanisms can serve positive and negative functions simultaneously. Defense mechanisms are used for healthy adaptation in the service of maturation, growth, and navigating social relationships, all while working to ward off anxiety, strong instinctual demands, and unconscious conflict instead of facing them (Cramer, 1991; Mahler & McDevitt, 1968).

In fact, research has generally shown that the use of mature defenses is linked to lower levels of psychological distress (Di Giuseppe et al., 2021). Mature defenses, compared to immature or neurotic defenses, are the most adaptive form because they do not distort conflict or impact affective experiences, but instead help integrate affects with ideas and lead to possible resolutions of distress (Vaillant, 1992). While immature defenses prevent any awareness of unacceptable ideas, feelings, and actions to protect individuals from feeling threatened, neurotic defenses indicate an individual's difficulty in holding both the emotional and cognitive aspects of conflict, as there is only capacity to hold emotions or cognitions one at a time. Similar to the False Self, neurotic defenses can keep the individual from being aware of all parts of the conflict (feelings, desires, and thoughts) to ward off anxiety (Di Giuseppe & Perry, 2021). Considering how higher overall defensive functioning is related to lower rates of depression and post-traumatic stress symptoms (Perry, 1990), there is an adaptive nature to defensive functioning, so long as it is not generalized to situations where no longer needed (Cramer, 1998).

Much of the empirical research using self-report measures of defensive functioning has occurred in the last couple of years. Using a population of individuals living in Italy during the first week of the COVID-19 pandemic lockdowns, research found that each increased unit of overall defensive functioning decreased the chances of post-traumatic stress symptomatology (Di Giuseppe, 2020a). This indicates that, in moments of intense threat and danger, defenses help individuals cope through the experience of the traumatic event itself. While this is a helpful framework to keep in mind, there are no studies that utilize self-report measures of defenses to assess their role in helping individuals navigate persistent experiences of potentially traumatic marginalization due to a culture of ableism.

Research exists on well-being and the use of defenses, highlighting that the use of mature defenses can increase well-being. For example, using the Scales of Psychological Well-Being (SPWB; Ryff & Keyes, 1995), Ziadni et al. (2017) explored how alexithymia, defense mechanisms, and ego strength are related, and how they can predict depression and psychological well-being in a sample of adult Midwestern Americans. These researchers identified principalization (or intellectualization) and isolation of affect as mature defenses, repression and reversal as somewhat less mature, and projection and acting out against self or others as immature. Findings highlighted that principalization and reversal were positively related to well-being, indicating the adaptive function of using less-immature defenses to maintain psychological equilibrium. Further research is needed to hone these dynamics in disabled populations.

Overall, even though research identifies the critical role of defense mechanisms in maintaining psychological equilibrium in times of intense psychic conflict and anxiety, no literature known to the researcher addresses the defense mechanisms disabled individuals employ to navigate a culture of ableism. Therefore, a specific aim of the current study is to expand our understanding of the False Self as a defense mechanism for disabled individuals in the context of surviving an overarching culture of interpersonal, intrapsychic, and institutional ableism.

Disability Identity Development

According to the Centers for Disease Control and Prevention (2023), the disability community is the largest minority in the United States, encompassing 27% of the population. Since disability can occur at any point across the lifespan and crosses race, socioeconomic status, gender identity, and sexual identity, researchers have had a difficult time reaching consensus on a model of the disabled identity or self-concept (Forber-Pratt et al., 2017). Disability identity development is generally defined as the extent to which disability informs one’s identity, including their internal beliefs about disability, their ability to tap into frustration with ableism, and their sense of closeness to the disability community (Forber-Pratt et al., 2020a). Considering the complex relationship among disavowing one's disability, social support, and the False Self, disability identity development holds a critical stake in this body of work. As explored by Myers et al. (1991), inherent in the process of identity development for those experiencing oppression or marginalization is consistent devaluation by others, which can yield a sense of self-devaluation and fragmentation. Although there are parallels to how the False Self is a response to consistent devaluation that leads to hiding one's marginalized identity, there are no empirical studies known to the researcher that assess the False Self and the outcome of disability identity integration.

Forber-Pratt et al. (2020a) operationalized factors of the disability identity by centering not only their own views of disability, but to what extent they are involved in the disability community. First, they highlighted "internal beliefs about one's own disability and the disability community" (Forber-Pratt et al., p. 5), which encompasses the beliefs, values, and experience of connection with others, as well as whether there is a pull to identify with those who are also disabled. The second factor includes "anger and frustration with disability" (Forber-Pratt et al., p. 5), characterized as the ability to tap into the frustrations of disability as a facet of acceptance, as it allows space for a nuanced relationship with one's body and social experiences rather than defending against them. The third factor is "adoption of disability community values" (Forber-Pratt et al., p. 5). This encompasses the disabled person's feeling of connection to the core values of the disabled community's activism to combat ableism. Since experience of disability is inherently political, as the ability to receive healthcare, access, and integration is tied to government policies and social attitudes, the researchers note that one's ability to advocate in their local community or on behalf of others is integral to the disabled identity. The fourth factor is “contribution to the disability community” (Forber-Pratt et al., p. 5). This could include public engagement, mentorship roles, or fundraising. Identity formation is an individual experience that relies on socialization, especially for disabled people whose lives are interdependent.

In this conceptualization of the disability identity, Forber-Pratt et al. (2020a) note the degree to which social support and interpersonal experiences are important facets. Therefore, the relationship among the disability identity, False Self, and social support becomes an important bridge that is absent from the literature. A critical role in a healthy disabled identity is the ability to achieve peer mentorships and relationships with other disabled people (Cohen, 2019). This is also an imperative concept in discussing the False Self, as it implies that a reduction in the desire to hide one’s disability is achieved through social environments where disability is actively held and met with mirroring. Much of the empirical literature on the False Self highlights the role of social support in buffering the intensity with which the False Self is relied on (Harter et al., 1996). Therefore, an important next step is to explore whether high levels of disability identity are a buffer or protective factor that keep the False Self at the optimal level of functioning.

Beyond social support, the extent to which one is open about one’s disability is another critical element to both disability identity and the False Self. In addition to the literature showing that the experience of microaggressions is linked to disavowal of one’s own disability (Eisenman et al., 2020), research on the disability identity demonstrates its positive relationship to greater well-being (Bogart, 2015; Chalk, 2015; Shmulsky, 2021).

Specifically, identifying openly as disabled is related to higher levels of self-esteem and mindfulness (Chalk, 2015), as well as lower levels of depression and anxiety (Bogart, 2015). However, research has not yet considered the disability identity alongside the False Self.

Overall, research has shown that coherently integrating disability into one's identity helps disabled individuals adapt, navigate social stressors, keep intact physical and psychological health, and provide access to a community of shared social support (Forber-Pratt et al., 2017). Additionally, difficulties in disabled identity achievement have been associated with a reluctance to disclose disability and ask for needed support or accommodations (Penick & Myers, 2019). However, as discussed in previous sections, not all social settings and environments are safe to be open with one's true experience of disability. Therefore, the present study aimed to: (1) Address the conceptual confusion about what factors contribute to disabled individuals being able to fully express their disability identity, versus utilize the False Self; and (2) dentify to what degree disability identity is a protective factor or buffer against an over-reliance on the False Self.

Chapter III

Statement of the Problem

Ableism, or discrimination based on disability, forces disabled individuals to navigate complex and emotionally demanding social dilemmas. While highlighting their disabilities is necessary in order to receive services and survive (Nishida, 2015), the extent to which disability is highlighted can also result in distress when met with social rejection and ableist microaggressions (Nario-Redmond, 2019). The impact of ableism, both institutionally and interpersonally, remains ever-present. Disabled individuals are left with the challenge of trying to receive care and acceptance from political and social systems that are ableist, and often internalize the message that they are not safely seen, known, or supported by others. Watermeyer (2012) therefore argues that disabled individuals must hone adaptive strategies for navigating such misattuned social climates—yet research on this complex phenomenon is limited.

On the one hand, ableist microaggressions teach disabled individuals that the world is not able to recognize their genuine expressions of disability, leading to the internalization of their disability as something to disown, overcome, or hide (Eisenman et al., 2020). Watermeyer (2012) highlights that this very closely mirrors Winnicott's (1960) False Self, where individuals learn there is a part of themselves they must hide in order to fit into their social environment. Other theorists argue that the experience of marginalization in America can be conceptualized as a broad scale representation of what can lead to the False Self (Bojarski & Qayyum, 2018). As with a mother not responding adequately to the needs of her child, and the child subsequently learning to present themselves in terms of what the mother will accept, the inability of social structures to recognize the injustices thwarted against marginalized people can produce similar reactions (Aymer, 2010). However, if one downplays or hides their disability, they do not receive care from larger social systems and will miss out on necessary disability accommodations that aid in their survival (Penick & Myers, 2019). Therefore, though there appears to be an optimal level of adaptive functioning in order to receive services, social support, and attunement from others, no literature exists on the psychological impact of this complex dilemma disabled individuals are forced into—or, more broadly, the consequence of disavowing one's identity. The following study aims to address this gap in the literature.

The first step is addressing how to conceptualize and operationalize the False Self in disabled populations. Watermeyer (2012) argues that the False Self in disabled lives can be conceptualized as an adaptive defense to navigating ableist social environments. Defense mechanisms are conceptualized as unconscious psychological operations that protect one from feeling anxiety about inner conflicts and external stressors, and aid one in getting their needs met in nonadaptive social environments (Cramer, 2000; Metzger, 2014). While the False Self has been conceptualized in theoretical literature as a type of defense that results in certain behaviors that allow adaptation to what the environment will support (Watermeyer, 2012), there are still no empirical studies known to the researcher that measure the False Self alongside a measure of defense in navigating extreme marginalization. Many recent empirical studies utilize the Defense Mechanism Rating Scale Self-Report-30 (DMRS-SR-30; Di Giuseppe et al., 2020), the newest measure with strong psychometric properties (Prout et al., 2021). These studies highlight that the use of defenses is linked to lower levels of psychological distress and decreased chances of developing post-traumatic stress symptomatology (Di Giuseppe, 2020a; Di Giuseppe et al., 2021). While the research does uphold the adaptive nature of defenses, further research is needed to contextualize defenses within other forms of hardship, such as extreme social and political marginalization. Further, these studies focus on distinct defenses that they group into categories of mature, neurotic, and immature. While this is helpful conceptually and matches the theoretical literature (Cramer, 1998), no studies known to the researcher measure the False Self alongside defense mechanisms.

In terms of how the False Self has been operationalized for empirical research, the Self-Relatedness and Environment-Directedness Scales (SREDS; Eichengreen & Hoofien, 2019) is a newer self-report measure of the False Self, and has been utilized only in a sample of deaf/hard of hearing (D/HoH) college students. Therefore, a critical aim of the study was to expand the conceptualization of the False Self by contextualizing it as a form of defense, while also expanding on the SREDS's psychometric properties, by using it in a broader population of disabled individuals.

Although many theorists argue the False Self is a complex and advantageous response to social environments that are not yet emotionally sophisticated enough to create a sustainable environment for marginalized identities (Aymer, 2010; Bojarski & Qayyum, 2018; Watermeyer, 2012), the empirical literature does not fully address the contexts in which the False Self could be a protective factor. Instead, most studies conceptualize the False Self as a pathological or nonadaptive way of relating. The False Self has been linked to insecure attachment styles, low self-esteem (Gil-Or et al., 2015), lower levels of conflict management, and lower levels of confidence in one's ability to provide emotional support in friendships (Sippola et al., 2007). However, all of these studies include samples of non-disabled adolescents that do not acknowledge levels of privilege and experiences of marginalization.

There exists only one empirical study known to the researcher that explores disability and the False Self. Specifically honing in on the intersection of disability and the False Self, Eichengreen and Hoofein's (2016) study utilized a sample of D/HoH college students. There were two main findings in this study: (1) A lack of social integration with non-disabled peers, and the child internalizing the idea that their disability is an impairment, is related to the low self-relatedness nature of False Self-defenses; and (2) Intensive rehabilitation programs designed to eradicate their disability, as well as parents ignoring their child's disability, are related to the high environment-directedness aspects of the False Self. While these findings importantly highlight how living with a deviant identity is related to the embodiment of the False Self, especially if there is a lack of social support, these social factors were not specifically addressed or conceptualized as experiences of ableism. Further, although these authors highlight the False Self as a reaction to these misattuned social experiences, they do not explore the False Self's role in maintaining well-being against this backdrop of constant social rejection and ableism, nor do they explore trying to hone at what degree or intensity the False Self no longer becomes advantageous.

Thirdly, if there exists this functional level of the False Self in maintaining well-being, no studies have assessed what contexts or factors may contribute. While disability identity, or the extent to which disability has been integrated in one's identity instead of disowned, has been positively correlated to well-being within a culture of ableism (Shmulsky, 2021), there are no studies that assess from the perspective of the False Self.

Disability identity involves two distinct factors: (1) The extent to which disability is interwoven in one's identity; and (2) The extent to which one is meaningfully involved in the disability community (Forber-Pratt, 2017). Considering both integration of one's identity (Winnicott, 1960) and levels of social support (Harter et al., 1996) hold critical stake in the False Self, a natural next step in the literature is to identify the role disability identity plays in the development of the False Self, as the disability identity exists at the intersection of one's sense of self and community. While Eichengreen and colleagues (2016) found that social support was a buffer against the development of the False Self in a sample of disabled college students, this was not explored as social support from the disability community specifically. Furthermore, while the extent to which disability is interwoven in one's identity and community is positively related to well-being and can ward some forms of lower well-being, such as depression or anxiety (Bogart, 2015; Chalk, 2015; Shmulsky, 2021), this has not yet been studied as a variable that can moderate the relationship among the False Self, ableism, and well-being.

Therefore, the present study sought to expand our conceptualization of how disabled individuals navigate a culture of ableism by honing a deeper understanding of the function of the False Self. Considering the SREDS is a newer measure of the False Self, the present study assessed self-relatedness and environment-directedness separately. The present research aimed to address the following three questions: (1) Can the False Self be conceptualized as a defense in this population? (2) Do extreme levels of the False Self contribute to well-being when ableism is present? (3) Does disability identity guard individuals from extreme levels of the False Self? In essence, the study aimed to clarify whether optimal levels of the False Self can aid individuals in achieving greater well-being against a culture of ableism, especially when disability identity is higher. Lastly, institutional ableism remains profound and ubiquitous—yet, its impact remains significantly under-researched in clinical psychology. Therefore, the present study aimed to sample participants that are currently enrolled in Medicaid home care programs. The study also incorporated exploratory research on how to operationalize government austerity in the realm of healthcare policy (which included understanding rates of trust in healthcare), as it is an under-researched yet critical experience in the everyday lives of disabled individuals.

Variable List

The following variables were assessed using self-report measures.

Predictor Variable: Ableist Microaggressions. Operationalized as one's awareness of disability-related microaggressions, using The Ableist Microaggression Scale (AMS; Conover et al., 2017). Total mean scores were computed.

Outcome Variable: Well-Being. Operationalized as overall psychological well-being, including one's mastery, social connectedness, and self-acceptance. This was measured using the Scales of Psychological Well-Being (SPWB; Ryff & Keyes, 1995). A total mean score was used to assess overall Well-Being, as well as total mean scores for each distinct subscale for exploratory analyses.

Proposed Moderating Variable: False Self (Self-Relatedness and Environment-Directedness). Utilizing the Self-Relatedness and Environment Directedness Scales (SREDS; Eichengreen & Hoofien, 2019), the False Self has been operationalized as low levels of Self-Relatedness and high levels of Environment-Directedness. As the SREDS is a newer measure that has not yet been utilized in a broader sample of disabled individuals to define the False Self, the present study explored the False Self as two distinct subscales in primary analyses:

- **A.** *Self-Relatedness*. Operationalized as awareness of emotions, levels of detachment, and spontaneity of expression, using sum scores of the Self-Relatedness subscale of the SREDS (Eichengreen & Hoofien, 2019).
- **B.** *Environment-Directedness*. Operationalized as compliance to others, sensitivity to others' mirroring, and a need for approval, using sum scores from the Environment-Directedness subscale of the SREDS (Eichengreen & Hoofien, 2019).

Proposed Moderating Variable: Disability Identity. Operationalized as the extent to which disability is integrated into one's identity and interpersonal life. It was assessed using the Disability Identity Scale (Forber-Pratt et al., 2020). Mean scores were computed. See Figures 1 and 2 for the models.

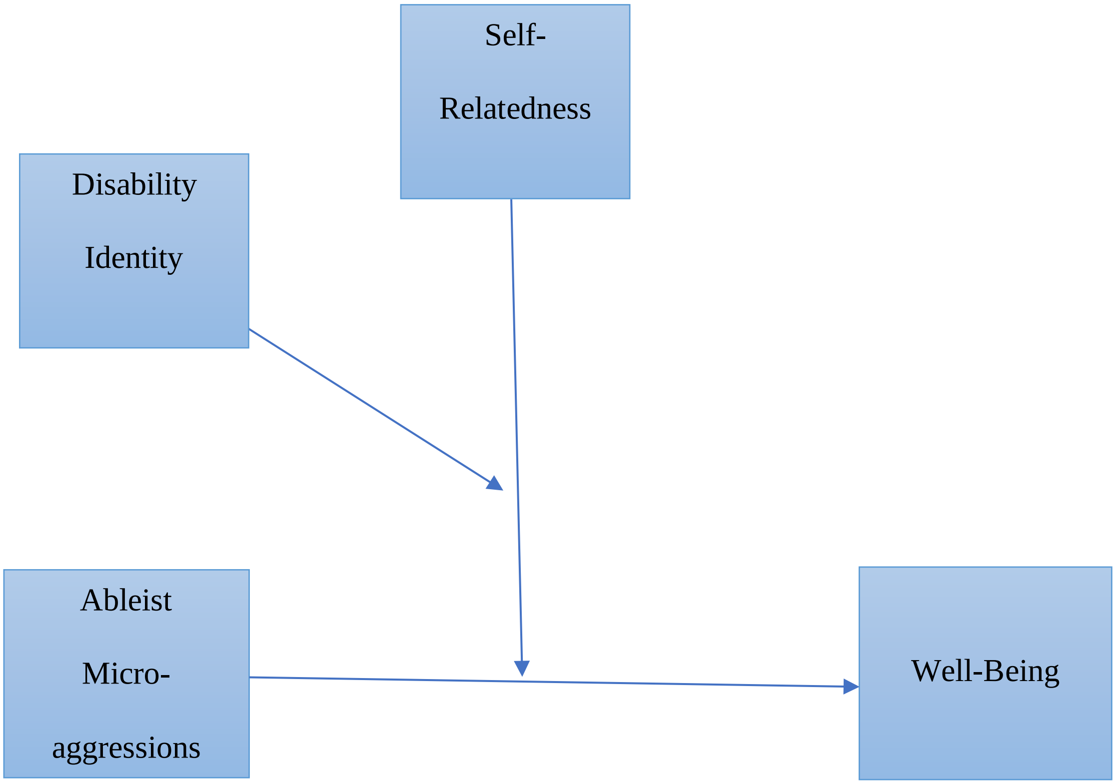
Exploratory Variables

Immature Defenses. Operationalized as the extent to which the individual utilizes an immature defense style. It was measured using sum scores of the Immature Defenses subscale of the Defense Mechanism Rating Scale-SR-30 (DMRS-SR-30; Di Giuseppe et al., 2020).

Neurotic Defenses. Operationalized as the extent to which the individual utilizes a neurotic defense style. It was measured using sum scores of the Neurotic Defenses sub-

Figure 1

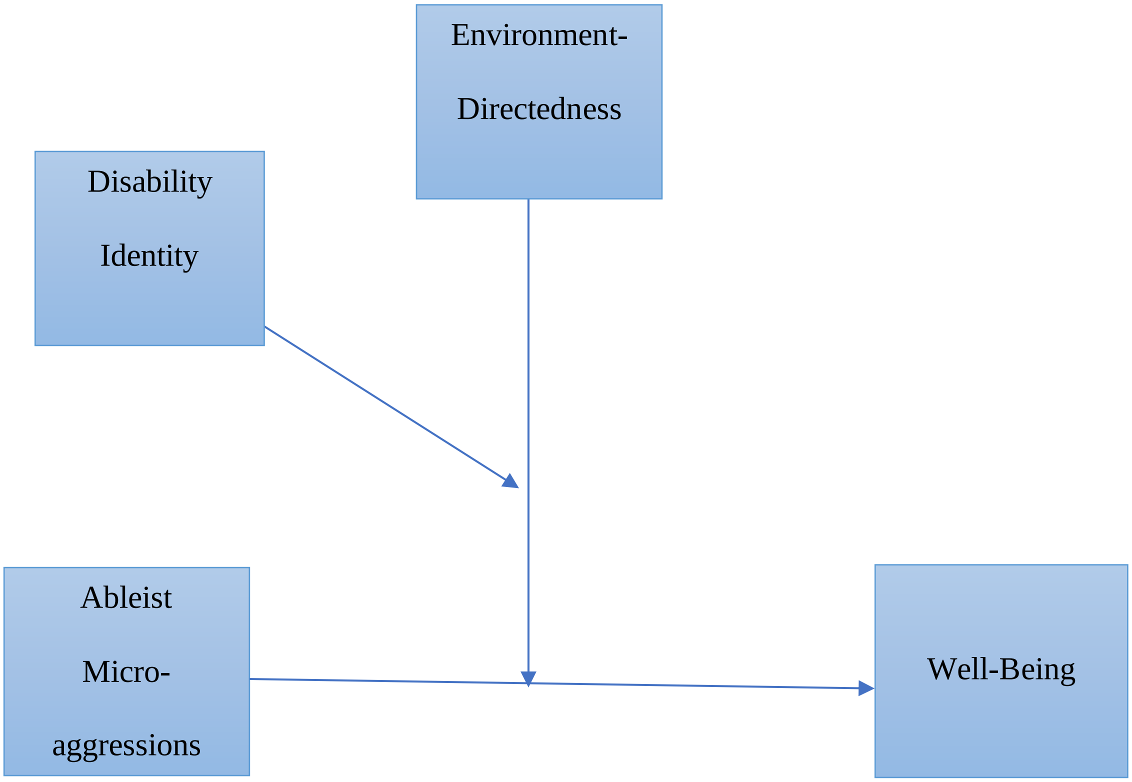
Proposed Model 1



Note. This moderated moderation model utilizes Hayes' PROCESS Model 3 (Hayes, 2012). It displays a model in which Self-Relatedness (Eichengreen & Hoofien, 2019) moderates the relationship between Ableist Microaggressions (Conover et al., 2017) and Well-Being (Ryff & Keyes, 1995). Additionally, it assesses how Disability Identity (Forber-Pratt et al., 2020) moderates the aforementioned moderated relationship.

Figure 2

Proposed Model 2



Note. This moderated moderation model utilizes Hayes' PROCESS Model 3 (Hayes, 2012). It displays a model in which Environment-Directedness (Eichengreen & Hoofien, 2019) moderates the relationship between Ableist Microaggressions (Conover et al., 2017) and Well-Being (Ryff & Keyes, 1995). Additionally, it assesses how Disability Identity (Forber-Pratt et al., 2020) moderates the aforementioned moderated relationship.

scale of the Defense Mechanism Rating Scale-SR-30 (DMRS-SR-30; Di Giuseppe et al., 2020).

Mature Defenses. Operationalized as the extent to which the individual utilizes a mature defense style. It was measured using sum scores of the Mature Defenses subscale of the Defense Mechanism Rating Scale-SR-30 (DMRS-SR-30; Di Giuseppe et al., 2020).

Trust in Healthcare. Measured to what extent participants trust that their direct providers, healthcare agencies, and payers for such services will meet their needs. This was assessed using the Multidimensional Trust in Health Care Systems Scale (MTHCSS; Egede & Ellis, 2008a). Four sum scores were utilized: a total score, as well as the three subscale scores (Trust in Providers, Trust in Payers, and Trust in Institution).

Medicaid Austerity Ailments. This is a researcher-generated scale created using McGrath's (2016) Austerity Ailments that assesses unmet home care needs of Medicaid enrollees and the impact of government austerity, which was piloted in this study.

Primary Hypotheses

In a sample of disabled adults recruited through social media and various disability organizations, it was hypothesized that:

Hypothesis 1. There will be a statistically significant and negative relationship between Ableist Microaggressions and Well-Being.

Hypothesis 2. There will be a statistically significant interaction effect of Self-Relatedness and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Self-Relatedness will report the lowest levels of Well-Being.

Hypothesis 3. There will be a statistically significant interaction effect of Environment-Directedness and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Environment-Directedness will report the lowest levels of Well-Being.

Hypothesis 4. There will be a statistically significant and positive relationship between Disability Identity and Well-Being.

Hypothesis 5. There will be a statistically significant three-way interaction effect of Disability Identity, Environment-Directedness, and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Environment-Directedness and lower levels of Disability Identity will report the lowest levels of Well-Being.

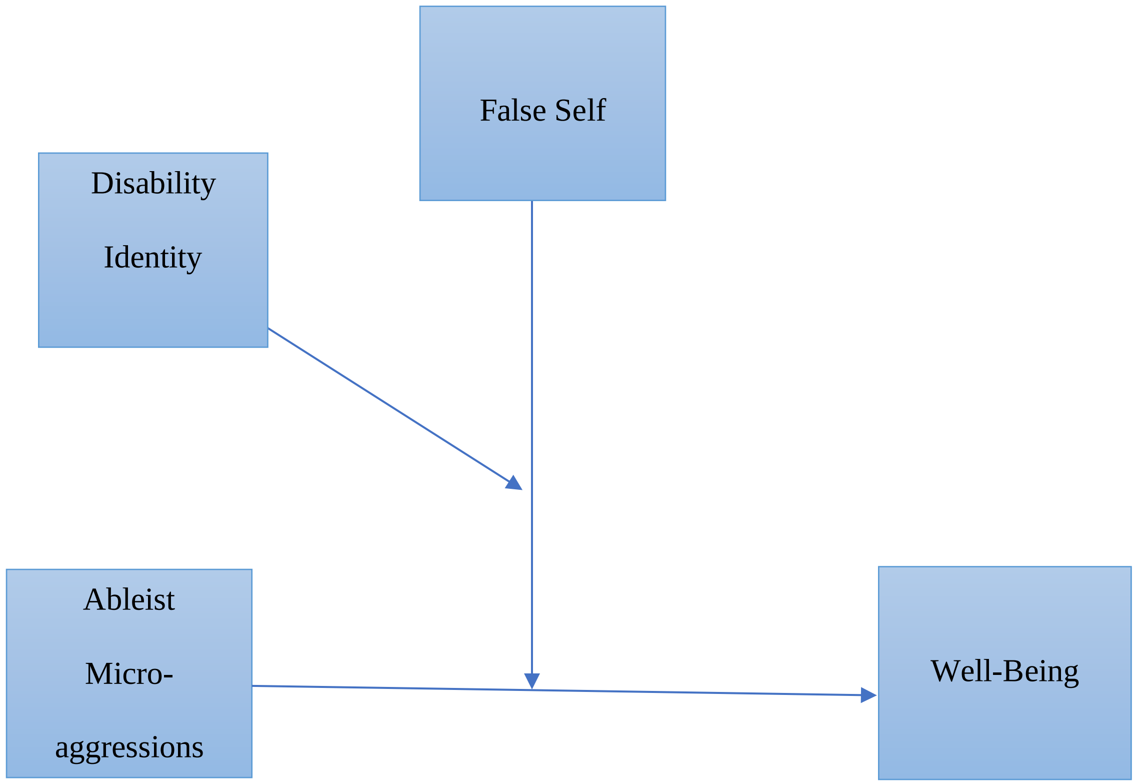
Hypothesis 6. There will be a statistically significant three-way interaction effect of Disability Identity, Self-Relatedness, and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Self-Relatedness and lower levels of Disability Identity will report the lowest levels of Well-Being.

Exploratory Questions

1) Are Environment-Directedness and Self-Relatedness empirically sound ways of measuring and conceptualizing the False Self?
2) Can the combined SREDS scale be used in the main moderated moderation model? See Figure 3.

Figure 3

Proposed Exploratory Model



Note. This moderated moderation model utilizes Hayes' PROCESS Model 3 (Hayes, 2012). It displays a model in which the False Self (Eichengreen & Hoofien, 2019) moderates the relationship between Ableist Microaggressions (Conover et al., 2017) and Well-Being (Ryff & Keyes, 1995). Additionally, it assesses how Disability Identity (Forber-Pratt et al., 2020) moderates the aforementioned moderated relationship.

3) Does satisfaction with Medicaid home care programs make an individual more likely to experience lower levels of Well-Being, Disability Identity, and Trust in Healthcare, but higher levels of Ableist Microaggressions and False Self?
4) Does high awareness of self-reported experiences of Ableist Microaggressions, low Trust in Healthcare, and low integration of Disability Identity integration relate to lower levels of Well-Being?
5) Can the Medicaid Austerity Ailments Scale be a psychometrically sound way to assess the intrapsychic impact of a withholding healthcare system for disabled individuals?

Chapter IV

Method

Participants

Inclusion criteria for participating in the study were identifying as having a disability and being in a Medicaid-funded home care program, in which they had been enrolled for at least one year. Disabled adults were defined as individuals 18 years or older with "a physical or mental impairment that substantially limits one or more major life activities of such individual" (Americans with Disabilities Act, 1990). Examples of disabilities that could qualify one for home care services included cerebral palsy, a spinal cord injury, and autism. Participants were recruited through social media, snowball sampling, and various organizations that work with or are connected to a network of disabled people across the United States.

The sample consisted of *N* = 329 participants between the ages of 18-51. This included 231 males (70.2%), 86 females (26.1%), 8 transgender males (2.4%), 4 transgender females (1.2%), and no nonbinary individuals. Sixty-one participants (18.5%) were aged 18-24, 194 (59.0%) were aged 25-34, 63 (19.1%) were aged 35-44, and 10 participants (3%) were 45 or older. The sample was predominately White (*n* = 242; 73.6%) and politically liberal (*n* = 148; 45.0%). Most of the sample had at least some undergraduate or graduate-level education (*n* = 216; 65.6%) and engaged in some form of employment or volunteer work (*n* = 269; 81.8%). Demographic characteristics of the sample are provided in Tables 1, 2, and 3. In terms of the sample's disability characteristics, the most common disabilities were physical (*n* = 83; 25.2%). The largest percentage of participants were enrolled in the traditional Home Care model within Medicaid (*n* = 162; 49.2%), while 112 participants (34%) were in the Consumer-Directed model and 54 (16%) were unsure. These findings are reported in Table 3.

G*power analysis V 3.1.9.7. (Faul et al., 2007) yielded a minimum total sample size of 119 participants. From the total 424 completed responses, 94 were excluded from analysis (22%). Of these excluded responses, 54 appeared to be inauthentic. These responses were eliminated as some portions of the optional open-ended responses were identical to each other. An additional three responses were eliminated due to open-ended questions being answered in a language other than English. An additional 21 responses were eliminated due to the individual not specifying that they met the criteria of being enrolled in a Medicaid-funded home care program. Sixteen responses were outliers on the Well-Being variable; they were three Standard Deviations (SD) above the mean and were subsequently removed. Lastly, one participant's response yielded residuals that were five SDs outside of the mean and was removed.

Measures

The following measures were presented in random order for each participant.

Demographics questionnaire. The survey contained several demographic questions assessing participant's disability, gender identity, ethnicity, age, disability status, and socio-economic status. It also included Likert-type scale questions and write-

Table 1

General Demographic Characteristics of Sample

Variable	*N*	%
Gender Identity		
Male	231	70.2
Female	86	26.1
Transgender male	8	2.4
Transgender female	4	1.2
Nonbinary	0	0
Age (in years)		
18-24	61	18.5
25-34	194	59.0
35-44	63	19.1
45+	10	3.0
Household Status		
Live with parents/family	175	53.2
Live with roommates/friends	58	17.6
Live alone	67	20.4
Live with significant other	29	8.8
Marital Status		
Single, never married	166	50.5
Partnered, never married	49	14.9
Married	92	28.0
Widowed	8	2.4
Divorced	8	2.4
Separated	6	1.8
Political Ideology		
Liberal	148	45.0
Conservative	77	23.4
Independent	75	22.8
No political ideology	25	7.6
Other	3	0.9
Ethnicity		
Hispanic/Latino	163	49.5
Non-Hispanic/Latino	162	49.2
Race		
White	242	73.6
Black or African American	39	11.9
American Indian/Alaskan Native	39	11.9
Asian	19	5.8
Native Hawaiian/Pacific Islander	14	4.3

Note. This table demonstrates demographic information of the 329 participants.

Table 2

Education and Employment Characteristics of Sample

Variable	*N*	%
Highest Education Level		
Some High School	52	15.8
GED/High School	61	18.5
Some college	89	27.1
Associate's degree	37	11.2
Bachelor's degree	69	21.0
Some Higher Education	13	4.0
Higher Education	8	2.4
Employment Status		
Full-time	166	50.5
Part-time	103	31.3
Not currently	51	15.5
Never worked	9	2.7
Employment Type		
Administrative/ Management	81	24.6
Temporary	61	18.5
Trained professional	61	18.5
None	55	16.7
Skilled labor	50	15.2
Retail	32	9.7
Student	24	7.3
Volunteer work	22	6.7
Other	8	2.4

Note. This table demonstrates employment status and educational background of the 329 participants.

Table 3

Disability-Related Characteristics of Sample

Variable	*N*	%
Type of Disability		
Physical	83	25.2
Chronic Illness	79	24.0
Neurological	53	16.1
Mental Illness	49	14.9
Hearing or vision	44	13.4
Communication	37	11.2
Cognitive	25	7.6
Other	13	4.0
Type of Home Care Program		
Traditional	162	49.2
Consumer-Directed	112	34.0
Not sure	54	16.4

Note. This table reports the varying types of disability in the sample, as well as the type of home care service utilized by the 329 participants.

in responses regarding their experiences with Medicaid and their families' acceptance of their disability for exploratory analyses. See Appendix B.

Disability Identity Scale (DIDS; Forber-Pratt et al, 2020). The DIDS is a 37-item self-report measure that assesses how one's sense of self includes one's disability and connection to the disabled community. There are four factors: (1) Internal beliefs about one's own disability and the disabled community, with sample items such as "I have a sense of belonging to the disability community"; (2) Anger and frustration with disability, with sample items such as "There are some days that I wish I did not have a disability"; (3) Adoption of the disabled community's values, with questions such as "If I witness someone else facing an access barrier, I do something about it"; and (4) Contribution to the disabled community, with questions such as "I organize events for the disability community." It is a continuous variable that utilizes a mean score, where higher scores indicate greater identity integration. The scale has a 4-point Likert-type scale ranging from 1 (*not at all like me*) to 4 (*very much like me*),

Forber-Pratt and colleagues (2020) initially constructed the scale from a qualitative study using a sample of disabled adults that identified four different disability identity constructs: (1) Acceptance of their disability status; (2) Relationship to other disabled people status; (3) Adoption of disability values status; and (4) Engagement in the disability community status. Following this, other studies utilized exploratory factor analysis (EFA) to create the specific 37 items and four categories. The resulting scale carries high internal consistency across all factors in a sample of disabled individuals:

Factor 1 (α = .94), Factor 2 (α = .91), Factor 3 (α = .81), and Factor 4 (α = .78). Further, because it is a newer measure, there aren't clear data on the scale's validity (Shmulsky et al., 2021). In the present study, the Cronbach's alpha estimate was high (α = .90), indicating that the participants used the measure in an internally consistent way.

Multidimensional Trust in Health Care Systems Scale (MTHCSS; Egede & Ellis, 2008a). The MTHCSS is a 17-item self-report measure that assesses to what extent one trusts: (1) Healthcare providers, with sample items such as "My health care provider is usually considerate of my needs and puts them first"; (2) Healthcare payers (i.e., insurance), with sample items such as "When needed, health care payers will pay for you to see any specialist"; and (3) Healthcare institutions to give adequate care and meet one's needs, with sample items such as "When treating my medical problems, health care institutions put my medical needs above all other considerations, including costs." The participants were instructed to respond to these items specifically about their Medicaid program and providers. It is a continuous variable that utilizes a sum score, where higher scores indicate greater trust that the system will meet their needs. The scale has a 5-point Likert-type scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*).

The scale was created utilizing focus groups, pilot studies, and principal component analyses to hone the multiple dimensions of trust already identified in the literature. This included agency/fidelity, competence, honesty, and confidentiality, all of which they found correlated enough to be studied as a single construct. The focus group participants were primarily composed of African American women that were recruited from a primary care clinic of an academic institution. Internal consistency for the overall scale was high (α = .89), while the subscales reported high to moderate Cronbach’s alpha (α = .92; α = .74; α = .64), respectively. Additionally, they reported moderate correlations between the MTHCSS and patient satisfaction ($r = .67$) and dissatisfaction ($r = .45$) with care (Egede & Ellis, 2008), indicating convergent validity. In the present study, the Cronbach’s alpha estimate was high (α = .86), indicating that the participants used the measure in an internally consistent way.

Self-Relatedness and Environment-Directedness Scales (SREDS: Eichengreen & Hoofien, 2019). The SREDS is a 30-item self-report measure that assesses two domains of the False Self as identified in literature: Self-Relatedness (SR) and Environment-Directedness (ED). It is a continuous variable that utilizes a mean score, where higher scores indicate greater reliance or embodiment of the False Self. It has a 5-point Likert-type scale ranging from 1 (*not at all characteristic of me*) to 5 (*extremely characteristic of me*). As the SREDS is a newer measure that has not yet been utilized in a broader sample of disabled individuals to define the False Self, the present study assessed SR and ED separately. Additionally, the “optimal level” of the False Self was operationalized as: (1) “high” levels of SR or ED, one standard deviation above the mean; and (2) “low” levels, one standard deviation below the mean. Sample items from SR include “I feel that there is a gap between how people perceive me and how I feel inside” and “I convey my enthusiasm spontaneously and without hesitation.” Sample items from ED include “Sometimes I devote too much attention to the way other people interpret my feelings" and "I tend to judge myself according to how I think others perceive me."

Eichengreen and colleagues (2016) validated the SREDS utilizing a sample of deaf/hard of hearing participants, and reported high internal consistency (α = .85). The present study examined SR and ED separately, as well as combined for a measure of False Self. Cronbach's alpha scores for SR ranged from .84 to .89, and ED from .92 to .90. The scale showed high criterion validity, as SR significantly correlated with Self-Determination Scale (SDS; Sheldon & Deci, 1996) while ED correlated with the Brief Fear of Negative Evaluation Scale (Leary, 1983; Eichengreen & Hoofien, 2019). In the present study, the Cronbach's alpha estimate was high for the overall scale (α = .92), as well as the ED (α = .86) and SR (α = .84) subscales.

Ableist Microaggressions Scale (AMS; Conover et al., 2017). The AMS is 20-item self-report measure that assesses one's frequency of experiencing four domains of Ableist Microaggressions. It is a continuous variable that utilizes a mean score, where higher scores indicate greater rates of perceived ableism in their lives. It has a 6-point Likert-type scale ranging from 0 (*never*) to 5 (*very frequently*). The four categories of ableism include: (1) Helplessness, with items such as "People express admiration for me because I have a disability"; (2) Minimization, with items such as "People act as if accommodations for my disability are unnecessary"; (3) Denial of Personhood, with sample items such as "People don't see me as a whole person because I have a disability"; and (4) Otherization, with sample items such as "People stare at me because I have a disability."

After conducting pilot studies to consolidate the 110 initial statements, Conover and colleagues (2017a) reported a high Cronbach's alpha (α = .92) for the final scale of 20 items in a sample of individuals that self-identified as having a disability. Internal consistency for the subscales were high as well: Helplessness (α = .85), Denial of Personhood (α = .90), Otherization (α = .84), and Minimization (α = .65). High construct validity was seen in the significant difference between responses from disabled and non-disabled participants. Convergent validity was tested with the Stigma Scale for Chronic Illness (*r* = .70; Rao et al., 2009). In the present study, the Cronbach's alpha estimate was high (α = .92), indicating that the participants used the measure in an internally consistent way.

Defense Mechanism Rating Scale-SR-30 (DMRS-SR-30; Di Giuseppe et al., 2020). The DMRS-SR-30 is a 30-item self-report measure that assesses one's hierarchy of defense mechanisms. It is a continuous variable that utilizes a mean score, where higher scores indicate more reliance on defenses. It has a 5-point Likert-type scale ranging from 0 (*not at all)* to 4 (*very often/much*). It was adapted after the original DMRS and DMRS-Q measures, which are interview and observer-rated measures. The DMRS-SR-30 highlights three defensive categories (Mature, Neurotic, and Immature), each of which carries its own distinct possible defense levels and mechanisms. The categories produce an Overall Defensive Functioning (ODF) score, where the higher the score, the more indication of overall defenses. The defensive categories, defense level, and mechanisms in the DMRS-SR-30 are outlined in Appendix A.

Participants were asked to note how often in the past week they “Perceived others as ‘all good’ or ‘all bad’” or “Complained about how others don’t understand or don’t really care,” among other items. Di Giuseppe and colleagues (2020) reported high internal consistency for the overall scale (α = .89,) as well as for the for the Mature (α = .70), Neurotic (α = .69), and Immature (α = .82) categories, as well as the Depressive (α = .76) and Other Immature (α = .58) subscales. There were high correlations between ODF and DMRS (*r* = .73; *p* < .01), as well as DMRS-Q (*r* = .63; *p* < .01), indicating convergent validity. In the present study, the Cronbach’s alpha estimate was high (α = .90), indicating that the participants used the measure in an internally consistent way. Reliability analyses using Cronbach’s alpha were also run for the three subscales used in the present study. The Mature subscale indicated acceptable reliability (α = .66), the Neurotic subscale indicated good reliability (α = .73), and the Immature subscale indicated high reliability (α = .84).

Scales of Psychological Well-Being (SPWB-42; Ryff & Keyes, 1995). This is a 42-item self-report measure to assess six domains of psychological Well-Being: Autonomy, Environmental Mastery, Personal Growth, Positive Relations with Others, Purpose in Life, and Self-Acceptance. It is a continuous variable that utilizes a mean score, where higher scores indicate greater levels of Well-Being. It has a 7-point Likert-type scale ranging from 1 (*strongly agree*) to 7 (*strongly disagree*). The categories produce an overall wellness score, as well as six distinct scores for each subscale. Twenty-one items were reverse-coded, so that the greater the score, the more indication of overall wellness. Sample items included “I enjoy making plans for the future and working to make them a reality” and “I have difficulty arranging my life in a way that is satisfying to me.”

While the SPWB has many versions that vary in length, the ultra-short versions were psychometrically problematic, while the longer versions led to respondent burnout (Gao & McLellan, 2018). Therefore, the 42-item version was chosen for this study because it performed relatively moderate internal consistency for the subscales, ranging from .69 to .85 (Morozink et al., 2010). Furthermore, recent research indicates that, in a sample of Canadian older adults with medical conditions, Cronbach’s alpha of the 42-item version of this scale ranged from .70 to .82 (Davidson et al., 2012). Additionally, correlations between the environmental mastery subscale of the SPWB-42 and a multidimensional measure of psychological distress showed a strong negative association (-.52), indicating predictive validity (Morozink et al., 2010). In the present study, the Cronbach’s alpha estimate was high (α = .94), indicating that the participants used the measure in an internally consistent way.

Medicaid Austerity Ailments (MAA). This is a researcher-generated questionnaire that was piloted in the present study for exploratory analyses, to assess unmet home care needs of Medicaid enrollees and the impact of government austerity. The scale was generated using the framework of McGrath et al.’s (2016) Austerity

Ailments. In addition to open-ended questions, it is a 38-item self-report measure that assesses three domains: Instability, Attunement, and Abuse. It is a continuous variable that utilizes a mean score, where greater scores indicate greater unmet needs and distress. It has a 5-point Likert-type scale ranging from 1 (*almost never true*) to 5 (*almost always true*). The overall scale has high reliability (α = .95), as do the Instability (α = .78), Misattunement (α = .79), and Abuse (α = .96) subscales.

Procedure

Participants were recruited using social media postings, snowball sampling, and through disability organizations. They were given a short description of the study and the link to the Qualtrics survey for participation. Once in the survey, they provided informed consent on the initial consent form (IRB #22/05-071). See Appendix D for the consent form. The consent form also instructed them to confirm eligibility criteria (that they had a disability, were at least 18 years of age, and had been enrolled in a Medicaid home care program for at least one year). No identifying information was collected, except if they entered their email address for the opportunity to win a raffle for participation. However, the email addresses collected were not linked to their survey responses. Participants were notified in the consent form that they would be answering questions about their personal lives and caregivers, so if they required help from a caregiver in order to complete the survey, they could be sure it was someone they were comfortable disclosing to.

The order of the measures was randomized automatically by Qualtrics. Participants were informed that identifying information would not be collected alongside their responses. Once the survey was completed, participants were shown the debriefing form and provided the opportunity to click a link to a separate survey for raffle entry with their email address. See Appendix D for the debriefing form. Two raffle winners, drawn at random, each received a $50 Amazon gift card.

Data Analytic Plan

Statistical analyses were conducted using SPSS Version 27.0 (2020). Preliminary analyses were completed to gather descriptive information on the sample, including but not limited to mean scores, missing data and outliers (univariate and multivariate), and tests of normality (skewedness or kurtosis). Bivariate correlations were completed using Pearson's correlation coefficient to assess how closely related the variables are. Cronbach's alpha computed measure internal consistency of the measures. Considering the regression model, multicollinearity and homoscedasticity were assessed and explored. One-sample *t*-tests were run to assess whether disabled individuals have differing levels of psychological well-being than the general population. Additionally, a simple correlation among the SREDS's three subscales of defenses (Mature, Immature, and Neurotic) was run to assess how closely the False Self may function similarly to Defenses.

The two main models of the present study were tested using Hayes PROCESS Model 3, and effects were all bootstrapped with 5,000 samples. The first model assessed whether the Self-Relatedness aspect of the False Self moderates the relationship between Ableist Microaggressions and Well-Being, and whether Disability Identity moderates this overall relationship. Meanwhile, the second model assessed whether the Environment-Directedness aspect of the False Self moderates the relationship between Ableist

Microaggressions and Well-Being, and whether Disability Identity moderates this overall relationship. If interactions were significant, they were probed and then plotted using the Johnson-Neyman (JN) technique to assess at what point along the distribution of the moderator the relationship between the predictor and outcome variables becomes significant.

The exploratory questions were organized into two categories: (1) Measuring the False Self as a whole; and (2) The impact of institutional ableism. Firstly, to assess whether Environment-Directedness and Self-Relatedness are an empirically sound way of measuring and conceptualizing the False Self, we combined the scales into one measure and conducted reliability analyses. Then, the overall False Self scale was used in the main moderation model to assess whether the False Self moderates the relationship between Ableist Microaggressions and Well-Being, and whether Disability Identity moderates this overall relationship.

The second aim was to explore institutional ableism. This included assessing the impact of Medicaid satisfaction on Well-Being, Disability Identity, Trust in Healthcare, Ableist Microaggressions, and the False Self. Then, a stepwise linear regression was run to assess whether high awareness of self-reported experiences of Ableist Microaggressions, low Trust in Healthcare, and low Disability Identity related to lower levels of Well-Being. Next, considering the dearth of research measuring the prevalence and impact of institutional ableism within the disability community, the researcher-generated Medicaid Austerity Ailments scale was piloted. Correlations among variables, reliability analyses, and descriptive statistics were also run.

Chapter V

Results

The following section is divided into three subsections: Preliminary Analyses (exploring descriptive statistics, assumptions testing, and normality testing), Main Analyses (focusing on the study's main hypotheses), and Exploratory Analyses (presenting the exploratory questions). Qualtrics recorded all participant responses, and IBM Statistical Package for the Social Sciences (SPSS) Statistics, Version 29 was used for all analyses in this study. The variables discussed will be capitalized.

Preliminary Analyses

Descriptive Statistics

Characteristics of the sample can be found in Tables 1, 2, and 3. To check distributions for normality, descriptive statistics and histograms were examined on the following variables: Well-Being, Self-Relatedness, Environment-Directedness, the False Self, Trust in Healthcare, Disability Identity, Ableist Microaggressions, as well as Mature, Neurotic, and Immature Defenses. These statistics are provided in Table 4. Shapiro-Wilk tests of normality showed all variables had a non-normal distribution. However, utilizing Hair et al.'s (2010) and Bryne's (2010) conceptualization of normal distributions as skewness between -2 to +2 and kurtosis between -7 to +7, none of the variables exceeded this range.

Tests of multicollinearity and heteroscedasticity were performed to ensure data met assumptions for the regression analyses in hypothesis testing. Variance inflation factors (VIF) revealed that none of the variables exceeded a score of 2, indicating that there were no correlations large enough to render the output unreliable. Additionally, the

White Test indicated heteroscedasticity, X^2 (43, N = 323) = 134.36, $p < .01$. There was one participant whose error terms were greater than three standard deviations above the mean and who was subsequently removed. Additionally, there were no extreme outliers ($D_1 < 1.00$) in the sample. Cook's Distance indicated five participants that had moderately high multivariate outliers (> .05). However, five outliers at this level are not of significant influence or leverage considering the mean value of .005. Therefore, these outliers remained in the sample.

Inter-Measure Correlations

Pearson correlation coefficients were calculated to test whether the variables were related as predicted (see Table 5). Effect sizes of the significant Pearson correlations were assessed based on the standard for the behavioral sciences, with .10, .30, .50 corresponding to small, medium, and large effect sizes, respectively (Cohen, 1988). Of note, moderate correlations were found between Self-Relatedness and Environment-Directedness ($r = -.50$, $p < .01$), Ableist Microaggressions ($r = -.32$, $p < .01$), and Well-Being ($r = .45$, $p < .01$). These findings indicate that those with higher levels of Self-Relatedness also experience greater Well-Being, while they experience less perceived Ableist Microaggressions. Moderate correlations were also found between Environment-Directedness and Ableist Microaggressions ($r = .47$, $p < .01$), as well as Disability Identity ($r = .36$, $p < .01$), indicating that the more swayed one is by their environment, the more perceptive they are to identifying Ableist Microaggressions and feeling like part of the disability community. Large correlations were found between Trust in Healthcare and Disability Identity ($r = .57$, $p < .01$), indicating that the more trust one has in the

Table 4

Descriptive Statistics of Variables

Variable	*M*	*SD*	Skew	Kurtosis
Ableist Microaggressions [a]	3.67	0.77	-.35	.49
False Self [b]	3.10	0.40	-.10	.42
Environment-Directedness	3.18	0.60	.16	.35
Self-Relatedness	2.98	0.33	.47	1.71
Disability Identity [c]	2.77	0.39	.42	.31
Trust in Healthcare [d]	3.39	0.52	.28	.27
Defenses [e]	4.58	0.15	.77	1.36
Mature	29.70	3.51	.87	2.20
Neurotic	24.85	2.13	.06	.91
Immature	45.48	3.14	-.76	.99
Well-Being [f]	3.62	0.36	1.70	3.98
Autonomy	3.60	0.45	.48	2.19
Self-Acceptance	3.63	0.48	.49	1.40
Purpose in Life	3.60	0.50	.72	1.58
Positive Relationships	3.76	0.58	1.22	2.25
Personal Growth	3.59	0.49	.67	.50
Environmental Mastery	3.57	0.55	.74	1.47

Note. This table demonstrates descriptive information of the measures utilizing the sample of 329 participants.

[a] Ableist Microaggressions Scale (Conover et al., 2017).

[b] Self-Relatedness and Environment-Directedness Scales (Eichengreen & Hoofien, 2019).

[c] Disability Identity Development Scale (Forber-Pratt et al., 2020).

[d] Multidimensional Trust in Health Care Systems Scale (Egede & Ellis, 2008).

[e] Defense Mechanism Rating Scale—Self Report—30 items (Di Giuseppe et al., 2020).

[f] Scales of Psychological Well-Being—42 items (Ryff & Keyes, 1995).

Table 5

Intercorrelations among Variables

	SR	ED	AMS	MA	NE	IM	DID	Trust	WB [f]
False Self (FS)	**-.80****	**.92****	**.48****	**-.29****	**.12***	**.24****	**.28***	**.16****	**-.32***
Self-Relatedness (SR) [a]		**-.50****	**-.32****	**.34****	**-.14***	**-.29****	-.07	.00	**.45****
Environment-Directedness (ED) [a]			**.47****	**-.19****	.08	**.15****	**.36****	**.23****	**-.17****
Ableist Microaggressions (AMS) [b]				**-.18****	.09	**.14***	**.15****	.07	**-.31****
Mature (MA) [c]					**-.46****	**-.81****	.11	**.19****	**.45****
Neurotic (NE) [c]						**-.16****	.04	-.06	**-.15****
Immature (IM) [c]							**-.15****	**-.17****	**-.40****
Disability Identity (DI) [d]								**.57****	**.24****
Trust in Healthcare (Trust) [e]									**.36****

Note. This table demonstrates correlations between the variables utilizing the sample of 329 participants.

[a] Self-Relatedness and Environment-Directedness Scales (Eichengreen & Hoofien, 2019).

[b] Ableist Microaggressions Scale (Conover et al., 2017).

[c] Defense Mechanisms Rating Scale-Self Report (Di Giuseppe et al., 2020).

[d] Disability Identity Development Scale (Forber-Pratt et al., 2020).

[e] Multidimensional Trust in Health Care Systems Scale (Egede & Ellis, 2008).

[f] WB = Well-Being; Scales of Psychological Well-Being—42 items (Ryff & Keyes, 1995).

healthcare system, the stronger their sense of their Disability Identity. Lastly, in addition to Self-Relatedness, Well-Being was also moderately correlated with Trust in Healthcare ($r = .36$, $p < .01$). This indicates that the greater trust one has in the healthcare system, the greater their psychological health.

Next, considering the significant correlations, some regressions were run between variables to test for predictive value. Firstly, a simple linear regression was used to assess if Disability Identity significantly predicted Well-Being. The overall regression was statistically significant, $R^2 = .06$, $F(1,327) = 19.7$, $p < .01$. It was found that Disability Identity significantly predicted Well-Being, $\beta = .24$, $p < .01$. Secondly, a simple linear regression was used to assess if Ableist Microaggressions significantly predicted Well-Being. The overall regression was statistically significant, $R^2 = .02$, $F(1,327) = 7.78$, $p < .05$. It was found that Ableist Microaggressions significantly predicted Well-Being, $\beta = .15$, $p < .05$. These two findings indicate that Disability Identity has a positive predictive impact on Well-Being, while Ableist Microaggressions have a negative predictive impact on Well-Being.

Subscales of Well-Being

The construct of Well-Being was further explored by delineating the six subscales: Autonomy, Environmental Mastery, Personal Growth, Positive Relationships with Others, Purpose in Life, and Self-Acceptance. Descriptive statistics for these subscales can also be found in Table 4. Overall, the sample exhibited greater levels of Positive Relationships ($M = 3.76$, $SD = 0.58$) than Personal Growth ($M = 3.59$, $SD = 0.49$; $t(328)$, $= -6.06$, $p < .01$), Environmental Mastery ($M = 3.57$, $SD = 0.55$; $t(328)$, $= 6.15$, $p < .01$), and Purpose in Life ($M = 3.59$, $SD = 0.50$; $t(328)$, $= -5.45$, $p < .01$). This indicates that, out of all six domains, the present sample experiences the most Well-Being in areas related to their social lives.

The False Self as a Defense

One aim of the study was to assess the construct validity of the False Self as a type of defense that functioned similarly in aiding Well-Being. Therefore, a specific focus of the preliminary analyses was to assess the relationship between the different types of defenses (Mature, Neurotic, Immature) and the False Self (including the two sub-categories, Self-Relatedness and Environment-Directedness). Correlations were first run using the two subscales of the False Self. As seen in Table 5, Mature Defenses had a medium correlation with Self-Relatedness ($r = .34$, $p < .01$), and a small correlation with Environment-Directedness ($r = -.19$, $p < .01$). This suggests that higher levels of Self-Relatedness and lower levels of Environment-Directedness are closely related to the utilization of a Mature Defense style. Meanwhile, Neurotic Defenses had a small negative correlation with Self-Relatedness ($r = -.14$, $p < .05$), indicating that Neurotic Defenses may be more closely related to lower levels of self-awareness. Lastly, Immature Defenses had a small negative correlation with Self-Relatedness ($r = -.29$, $p < .01$) and a small positive correlation Environment-Directedness ($r = .15$, $p < .01$), indicating that Immature Defenses are more closely related to lower self-awareness and a tendency to be swayed by one’s environment.

Next, correlations were run between the three defense styles and the False Self construct as a whole. Data indicated small positive correlations between the False Self and Neurotic Defenses ($r = .12$, $p < .05$) and Immature Defenses ($r = .24$, $p < .01$), but not Mature Defenses. In fact, there was a significant negative correlation between Mature

Defenses and the False Self (*r* = -.29, *p* < .01). Concurrent validity between the False Self and Neurotic and Immature Defenses suggests that the False Self may function similarly to those sorts of defense styles, but not Mature Defenses. In other words, the presentation of the False Self is more closely related to a Neurotic or Immature Defense.

Differences Between Sample and Population Means

One-sample *t*-tests were run to assess whether the study sample had differing levels of defenses from the population mean. The DMRS-SR-30 (Di Giuseppe et al., 2020) was normed on a sample of 92 individuals living in Tuscany, Italy that had been living in lockdown during the COVID-19 pandemic for two months. That sample was predominantly female (62%), unmarried (81%) students (65%) with an average age of 25.5 years. In contrast, the present study's sample displayed significantly lower levels of Mature Defenses (*M* = 29.67, *SD* = 3.50) than the above sample that the scale was normed on (*M* = 38.17, *SD* = 8.84, *t*(322) = -43.59, *p* < .01). Additionally, they had a significantly higher level of Neurotic Defenses (*M* = 24.86, *SD* = 2.13) than the population the scale was normed on (*M* = 23.02, *SD* = 5.79, *t*(322) = 14.48, *p* < .01). Lastly, they had a significantly higher level of Immature Defenses (*M* = 45.48, *SD* = 3.15) than the population the scale was normed on (*M* = 38.76, *SD* = 8.54, *t*(322) = 38.35, *p* < .01).

Rates of Ableist Microaggressions

The Ableist Microaggressions Scale (Conover et al., 2017) comprises four subscales: Helplessness (*M* = 3.71, *SD* = .76), Minimization (*M* = 3.83, *SD* = 1.00), Denial of Personhood (*M* = 3.59, *SD* = .91), and Otherization (*M* = 3.61, *SD* = .88). On average, 27% of participants reported experiencing Ableist Microaggressions related to other's perceiving them as Helplessness. Roughly 30% of participants endorsed experiencing Ableist Microaggressions related to others minimizing their disability. Roughly 23% of participants endorsed experiencing Ableist Microaggressions related to others denying their personhood. Lastly, about 25% of participants endorsed experiencing Ableist Microaggressions related to feeling otherized. See Table 6 for the full rates of Ableist Microaggressions that the sample endorsed.

Considering these high rates, a linear regression analysis was run to evaluate the extent to which each type of Ableist Microaggression could predict Well-Being. A significant regression was found, $F(4, 324) = 19.60$, $p < .01$. Results indicated that 20% of the variance in Well-Being could be explained by the four types of Ableist Microaggressions; however, it varied based on type. For example, Denial of Personhood ($\beta = -.21$, $p < .05$) and Otherization ($\beta = -.31$, $p < .01$) had a negative impact on Well-Being, indicating that greater levels of these forms of Ableist Microaggressions could predict a reduction in Well-Being. However, Helplessness had the opposite effect. As participants endorsed more of the Ableist Microaggression Helplessness, their Well-Being increased, $\beta = .3$, $p < .01$. Lastly, Minimization had no significant impact on Well-Being, $\beta = .14$, $p = .06$. In sum, Ableist Microaggressions in the form of being otherized or having one's personhood denied predicted lower Well-Being, while the experience of Ableist Microaggressions in the form of others viewing one as helpless positively predicted higher Well-Being.

Table 6

Endorsements of Ableist Microaggressions

Item	Likert-Scale					
	0	1	2	3	4	5
Helplessness						
People feel they need to do something to help me because I have a disability.	5.2%	11.9%	24.6%	30.4%	21.6%	6.4%
People express admiration for me or describe me as inspirational simply because I live with a disability.	4.0%	10.6%	22.8%	35.0%	21.0%	6.7%
People express pity for me because I have a disability.	3.6%	10.3%	22.2%	35.3%	21.3%	7.3%
People do not expect me to have a job or volunteer activities because I have a disability.	4.9%	28.0%	28.0%	33.1%	15.8%	5.2%
People offer me unsolicited, unwanted, or unneeded help because I have a disability.	4.0%	11.6%	28.3%	30.1%	21.6%	4.6%
Minimization						
People are unwilling to accept that I have a disability because I appear able-bodied.	5.8%	9.1%	15.5%	32.2%	19.8%	14.6%
People minimize my disability or suggest that it could be worse.	5.2%	12.2%	28.3%	32.8%	18.8%	2.7%
People act as if accommodations for my disability are unnecessary.	6.4%	7.9%	19.5%	26.7%	22.2%	13.3%
Denial of Personhood						
People don’t see me as a whole person because I have a disability.	5.8%	11.6%	22.8%	31.9%	19.5%	8.2%
People act as if I am nothing more than my disability.	4.6%	15.2%	24.9%	30.7%	18.5%	6.1%
People speak to me as if I am a child or do not take me seriously because I have a disability.	8.2%	11.2%	27.7%	30.1%	15.8%	7.0%
People assume I have low intelligence because I have a disability.	10.3%	12.5%	26.7%	26.4%	19.1%	4.9%
Because I have a disability, people attempt to make decisions for me that I could make myself.	7.3%	11.6%	22.8%	38.3%	14.6%	5.5%

Table 6 (continued).

Item	Likert-Scale					
	0	1	2	3	4	5
Otherization						
People think I should not date or pursue sexual relationships because I have a disability.	6.4%	12.8%	27.7%	27.1%	17.9%	8.2%
People indicate that they would not date a person with a disability.	6.1%	12.2%	28.3%	26.1%	20.4%	7.0%
People suggest that I cannot or should not have children because I have a disability.	7.9%	11.9%	22.5%	34.0%	18.8%	4.9%
People stare at me because I have a disability.	4.9%	9.7%	14.9%	26.4%	24.6%	14.6%
Because I have a disability, people seem surprised to see me outside my home.	5.5%	12.5%	28.3%	36.2%	13.7%	4.0%
Because I have a disability, people assume I have an extraordinary gift or talent.	7.6%	13.4%	29.8%	27.4%	15.2%	6.7%
People suggest that living with a disability would not be a worthwhile existence.	9.4%	16.4%	25.2%	28.6%	14.6%	5.8%

Note. 0 = Never; 1 = Very Rarely; 2 = Rarely; 3 = Occasionally; 4 = Frequently; 5 = Very Frequently

Percentages indicate what portion of the sample of 329 participants endorsed the item at that rate. These items and categories are from the Ableist Microaggressions Scale (Conover et al., 2017)

Primary Analyses

Primary Model 1

The first model was tested using Hayes' PROCESS Model 3 bootstrapped to 5,000 samples. This moderated moderation model assessed how the interaction effect between Ableist Microaggressions and Self-Relatedness on Well-Being was moderated by Disability Identity. The relevant hypotheses for this model are as follows: (1) There will be a statistically significant and negative relationship between Ableist Microaggressions and Well-Being; (2) There will be a statistically significant interaction effect of Self-Relatedness and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Self-Relatedness will report the lowest levels of Well-Being; (4) There will be a statistically significant and positive relationship between Disability Identity and Well-Being; and (6) There will be a statistically significant three-way interaction effect of Disability Identity, Self-Relatedness, and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Self-Relatedness and lower levels of Disability Identity will report the lowest levels of Well-Being. Hypotheses 3 and 5 are addressed in the second model.

The overall model was found to be significant, $R^2 = .59$, $F(7, 320) = 25.31$, $p < .01$. See Table 7 for full results. All direct effects in the model were significant. Results within the tested model indicated a statistically significant and negative direct effect of Ableist Microaggressions on Well-Being ($b = -.08$, $p < .01$, 95% CI [-.1333, -.0333]), indicating that greater Ableist Microaggressions predicts lower levels of Well-Being. Therefore, Hypothesis 1 was supported. There was a significant and positive direct effect

Table 7

Regression Analyses for Main Analyses Model 1

Variable	*b*	95% CI		*SE*
		LL	*UL*	
Constant	3.62***	3.58	3.65	.02
Main effect				
Ableist Microaggressions (AMS)	-.08**	-.13	-.03	.03
Self-Relatedness (SR)	.40***	.30	.51	.05
Disability Identity (DI)	.28***	.19	.37	.05
Two-Way Interaction				
AMS x SR	-.16*	-.31	-.01	.08
AMS x DI	-.01	-.12	.10	.06
SR x DI	.53***	.22	.83	.15
Three-Way Interaction				
AMS x SR x DI	.51*	.14	.88	.19

Note. This table demonstrates the results of Hayes PROCESS Model 3 (2012) utilizing 329 participants. The model investigates how Self-Relatedness (Eichengreen & Hoofien, 2019) moderates the impact of Ableist Microaggressions (Conover et al., 2017) on Well-Being (Ryff & Keyes, 1995). Additionally, it assesses how Disability Identity (Forber-Pratt et al., 2020) moderates the aforementioned moderated relationship.

CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit; *SE* = Standard Error

**p* < .05. ** *p* < .01. ** *p* < .01.

of Self-Relatedness on Well-Being, *b* = .40, *p* < .01, 95% CI [.2956, .5087]. This finding indicates that, in this model, those with higher levels of Self-Relatedness also reported greater levels of Well-Being. Thirdly, there was a significant and positive direct effect of Disability Identity on Well-Being, *b* = .28, *p* < .01, 95% CI [.1869, .3669]. Therefore, Hypothesis 4 was supported in this model, as those with greater levels of Disability Identity reported better overall Well-Being.

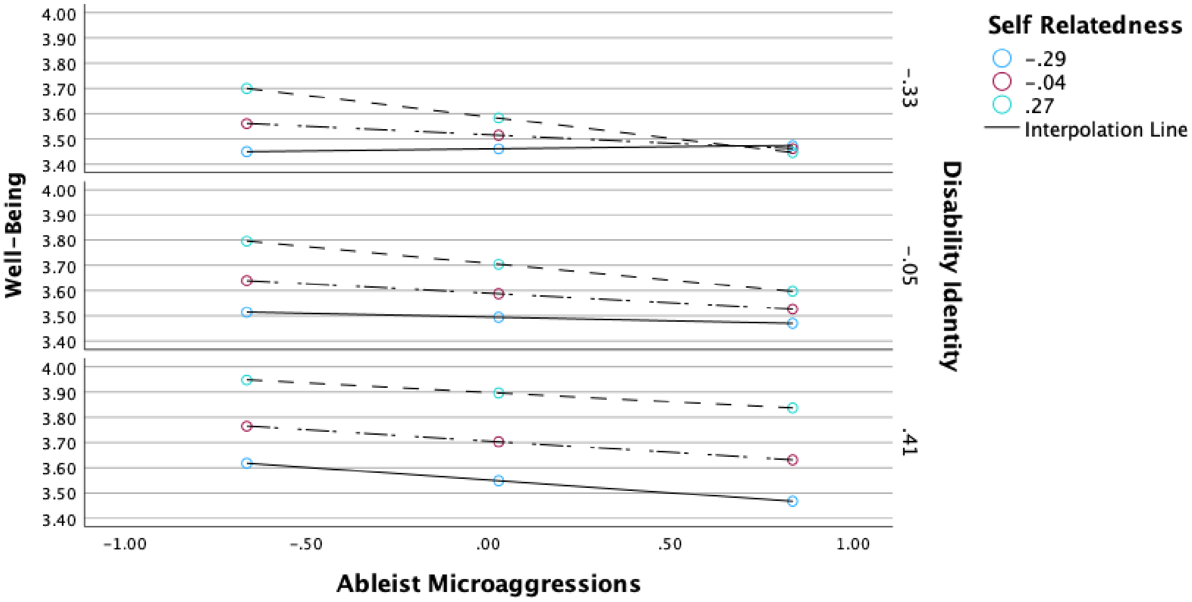
There were two statistically significant two-way interaction effects in the model. Firstly, there was a significant negative interaction effect of Ableist Microaggressions and Self-Relatedness on the prediction of Well-Being, *b* = -.16, *p* < .05, 95% CI [-.3141, -.0074]. However, when a separate moderation analysis was run without the Disability Identity variable to probe and plot the two-way interaction further, the interaction effect of Ableist Microaggressions and Self-Relatedness on Well-Being was no longer significant, *b* = -.07, *p* = .34, 95% CI [-.1993, .0685]. Therefore, Hypothesis 2 was not supported. This finding may suggest the inclusion of Disability Identity as an additional moderating variable in the model significantly affects how Ableist Microaggressions and Self-Relatedness impact Well-Being. Secondly, the interaction effect of Self-Relatedness and Disability Identity on Well-Being was significant and positive in the model, *b* = .53, *p* < .01, 95% CI [.2236, .8306]. When this interaction was probed and plotted further using Johnson-Neyman technique, results indicated that as Self-Relatedness and Disability Identity increases, Well-Being also increases. The third two-way interaction, the effect of Ableist Microaggressions and Disability Identity on the prediction of Well-Being, was not significant, *b* = -.01, *p* = .88, 95% CI [-.1224, .1044].

Lastly, there was a positive and significant three-way interaction effect of Disability Identity, Self-Relatedness, and Ableist Microaggressions on the prediction of Well-Being, *b* = .51, *p* < .01, 95% CI [.1286, .8804]. When the interaction was probed and plotted using Johnson-Neyman technique, the effect of the relationship between Ableist Microaggressions and Self-Relatedness on Well-Being was found to be negatively significant as levels of Disability Identity decreased. This suggests that when Disability Identity is low, people with high levels of Self-Relatedness that experience greater levels of Ableist Microaggressions have lower levels of Well-Being, 95% CI [-.3185, -.0093]. By contrast, the effect of the relationship between Ableist Microaggressions and Self-Relatedness on Well-Being was found to be positively significant as levels of Disability Identity increased. This suggests that when Disability Identity is high, people with high levels of Self-Relatedness who also experience greater Ableist Microaggressions have greater Well-Being, 95% CI [.0139, .5761]. This could indicate that in people with high levels of Self-Relatedness, Disability Identity acts as a buffer to the detrimental impact of Ableist Microaggressions on overall Well-Being. Therefore, Hypothesis 6 was partially supported, as there was an interaction effect of Disability Identity, Self-Relatedness, and Ableist Microaggressions on Well-Being but not in the expected direction. See Figure 4 for a graph of this interaction using PROCESS.

Considering the important role of Disability Identity, a simple regression was run to assess the impact of Ableist Microaggressions on Well-Being at different levels of the Disability Identity, as identified by the three-way interaction. However, the model was

Figure 4

Three-Way Interaction Effect of Model 1



Note. This figure demonstrates the three-way interaction effect between Ableist Microaggressions (Conover et al., 2017), Disability Identity (Forber-Pratt et al., 2020), and Self-Relatedness (Eichengreen & Hoofien, 2019) on Well-Being (Ryff & Keyes, 1995).

Mean values were centered in the analyses.

Red corresponds to the mean value of Self-Relatedness (-.04), green to one SD below the mean (-.29), and blue to one SD above the mean (.27).

not significant. This indicates the importance of the three-way interaction, as Disability Identity alone did not have a significant impact on Well-Being.

Primary Model 2

The second model was tested using Hayes' PROCESS Model 3 bootstrapped to 5,000 samples. This moderated moderation model assessed how the size and direction of the interaction effect between Ableist Microaggressions and Environment-Directedness on Well-Being was moderated by Disability Identity. The relevant hypotheses for this model are as follows: (1) There will be a statistically significant and negative relationship between Ableist Microaggressions and Well-Being; (3) There will be a statistically significant interaction effect of Environment-Directedness and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Environment-Directedness will report the lowest levels of Well-Being; (4) There will be a statistically significant and positive relationship between Disability Identity and Well-Being; and (5) There will be a statistically significant three-way interaction effect of Disability Identity, Environment-Directedness, and Ableist Microaggressions on Well-Being, such that individuals with the highest or lowest levels of Environment-Directedness and lower levels of Disability Identity will report the lowest levels of Well-Being. (See Table 8 for results.)

The overall model was found to be significant, $R^2 = .20$, $F(7, 321) = 11.56$, $p < .01$. All direct effects were significant in the model. There was a significant and negative direct effect of Ableist Microaggressions on Well-Being, $b = -.11$, $p < .01$, 95% CI [-.1802, -.0485]. Hypothesis 1 was therefore supported in this model, as more

Table 8

Regression Analyses for Main Analyses Model 2

Variable		95% CI		
	b	*LL*	*UL*	*SE*
Constant	3.63***	3.59	3.67	.02
Main effect				
Ableist Microaggressions (AMS)	-.11***	-.18	-.05	.03
Environment-Directedness (ED)	-.09*	-.17	-.01	.04
Disability Identity (DI)	.33***	.22	.43	.06
Two-way Interaction				
AMS x ED	.01	-.8	.09	.05
AMS x DI	.02	-.13	.17	.08
ED x DI	-.16	-.36	.03	.10
Three-way Interaction				
AMS x ED x DI	-.12	-.29	.05	.09

Note. This table demonstrates the results of Hayes PROCESS Model 3 (2012) utilizing 329 participants. The model investigates how Environment-Directedness (Eichengreen & Hoofien, 2019) moderates the impact of Ableist Microaggressions (Conover et al., 2017) on Well-Being (Ryff & Keyes, 1995). Additionally, it assesses how Disability Identity (Forber-Pratt et al., 2020) moderates the aforementioned moderated relationship.

CI = Confidence Interval; *LL* = Lower Limit; *UL* = Upper Limit; *SE* = Standard Error

*$p < .05$. ** $p < .01$. ** $p < .01$.

Ableist Microaggressions indicated lower levels of Well-Being. Secondly, there was a positive and negative direct effect of Environment-Directedness on Well-Being, (*b* = -.09, *p* < .05, 95% CI [-.1704, -.0087]), suggesting that more Environment-Directedness can predict lower Well-Being. Lastly, there was a positive and significant direct effect of Disability Identity on Well-Being (*b* = .33, *p* < .01, 95% CI [-.2177, .4346]), indicating that Disability Identity has a positive impact on Well-Being. Therefore, Hypotheses IV was supported.

However, none of the interaction effects were significant in this model. Firstly, there was no significant interaction effect of Ableist Microaggressions and Environment-Directedness on Well-Being, *b* = .01, *p* = .85, 95% CI [-.0752, .0912]. Therefore, Hypothesis 3 was not supported, as Environment-Directedness did not moderate the relationship between Ableist Microaggressions and Well-Being in this model. Secondly, there was no significant interaction effect of Ableist Microaggressions and Disability Identity on the prediction of Well-Being in this model, *b* = .02, *p* = .81, 95% CI [-.1333, .1708]. Thirdly, the interaction effect of Environment-Directedness and Disability Identity on Well-Being was not significant, *b* = -.16, *p* = .10, 95% CI [-.3577, .0322]. Lastly, the three-way interaction effect of Disability Identity, Environment-Directedness, and Ableist Microaggressions on the prediction of Well-Being was not significant, *b* = -.12, *p* = .15, 95% CI [-.2932, .0464]. Therefore, Hypothesis 5 was not supported, as there was not a significant three-way interaction effect of Disability Identity, Environment-Directedness, and Ableist Microaggressions on Well-Being. These findings indicate that Environment-Directedness does not play a significant role in the relationships between Ableist Microaggressions, Disability Identity, and Well-Being.

Summary. Two primary models were tested: one that assessed the self-relatedness aspect of the False Self, and another that assessed Environment-Directedness. The primary findings illuminate overall the critical role of Self-Relatedness in the present sample, as Environment-Directedness did not have a significant role in the interaction effects of the model.

The first model assessed the impact of Self-Relatedness and Disability Identity on the relationship between Ableist Microaggressions and Well-Being. In the context of this model, Self-Relatedness and Disability Identity displayed a positive direct impact on Well-Being. This implies that higher levels of Self-Relatedness and Disability Identity predict greater Well-Being outcomes. However, the interaction of Ableist Microaggressions and Self-Relatedness on Well-Being, as well as the interaction of Ableist Microaggressions and Disability Identity on Well-Being, were not significant.

Additionally, the three-way interaction effect produced interesting results. In the context of those with lower levels of Disability Identity, those with higher levels of Self-Relatedness and greater experiences of Ableist Microaggressions reported lower levels of Well-Being. In contrast, in those with greater levels of Disability Identity, more experiences of Ableist Microaggressions and Self-Relatedness produced better Well-Being outcomes. These findings illuminate that lowest levels of Well-Being are reported in those that experience increased Ableist Microaggressions and a strong sense of self, yet struggle with their Disability Identity. They also indicate that highest levels of Well-Being are reported in those that have a strong sense of self and Disability Identity when experiencing increased Ableist Microaggressions. In summary, Disability Identity may act as a buffer to the negative impact of Ableist Microaggressions.

Exploratory Analyses

False Self as a Measurable Construct

One aim of the exploratory analyses was to further the operationalization of the False Self construct by combining Self-Relatedness and Environment-Directedness, as introduced by Eichengreen and Hoofien (2017). Overall, the False Self measure was used reliably by the participants in this study ($\alpha = .92$). Data were normally distributed and did not display any significant skewness (-.10) or kurtosis (.42). Correlations are reported in Table 5.

Next, the False Self construct (combined Environment-Directedness and Self-Relatedness subscales) was used as a moderator in the main model. The model was tested using Hayes' PROCESS Model 3 bootstrapped to 5,000 samples. This moderated moderation model assessed how the interaction effect between Ableist Microaggressions and the False Self on well-being was moderated by Disability Identity. The overall model was found to be significant, $R^2 = .28$, $F(7, 316) = 17.15$, $p < .01$. See the full results in Table 9.

Results indicated two significant direct effects in the model. Firstly, there was a significant and negative direct effect of False Self on Well-Being, $b = -.30$ $p < .01$, 95% CI [-.4183, -.1878]. This finding indicates that, in this model, those with higher levels of the False Self reported lower levels of Well-Being. Secondly, there was a significant and positive direct effect of Disability Identity on Well-Being, $b = .34$ $p < .01$, 95% CI [.2346, .4381]. Meanwhile, there was not a statistically significant direct effect of Ableist Microaggressions on Well-Being, $b = -.06$, $p = .07$, 95% CI [-.1187, .0050]. This suggests

Table 9

Regression Analyses for Exploratory Regression

Variable	*b*	95% CI		*SE*
		LL	*UL*	
Constant	3.63***	3.59	3.67	.02
Main effect				
Ableist Microaggressions (AMS)	-.06	-.12	-.01	.03
False Self (FS)	-.30***	-.42	-.19	.06
Disability Identity (DI)	.34***	.23	.44	.05
Two-way Interaction				
AMS x FS	.05	-.07	.18	.06
AMS x DI	.01	-.14	.15	.07
FS x DI	-.27	-.55	.02	.15
Three-way Interaction				
AMS x FS x DI	-.31*	-.58	-.05	.14

Note. This table demonstrates the results of Hayes PROCESS Model 3 (2012) utilizing 329 participants. The model investigates how False Self (Eichengreen & Hoofien, 2019) moderates the impact of Ableist Microaggressions (Conover et al., 2017) on Well-Being (Ryff & Keyes, 1995). Additionally, it assesses how Disability Identity (Forber-Pratt et al., 2020) moderates the aforementioned moderated relationship.

CI = confidence interval; *LL* = lower limit; *UL* = upper limit; *SE* = Standard Error

**p* < .05. ** *p* < .01. ** *p* < .01.

that, within this model, the False Self and Disability Identity alone have a significant impact on Well-Being, while Ableist Microaggressions do not.

There were no statistically significant two-way interaction effects in the model. There was not a significant interaction effect of Ableist Microaggressions and False Self on the prediction of Well-Being, $b = .06$, $p = .38$, 95% CI [-.0689, .1808]. There was not a significant interaction effect of Ableist Microaggressions and Disability Identity on the prediction of Well-Being, $b = .01$, $p = .94$, 95% CI [-.1356, .1469]. Lastly, the interaction effect of False Self and Disability Identity on Well-Being was not significant, $b = -.27$, $p = .06$, 95% CI [-.5545, .0159].

Finally, there was a negative and significant three-way interaction effect of Disability Identity, False Self, and Ableist Microaggressions on the prediction of Well-Being, $b = -.31$, $p = .021$, 95% CI [-.5791, -.0472]. When probed and plotted further using the Johnson-Neymen technique, data indicated the impact of Disability Identity at varying levels. For example, at low levels of Disability Identity, higher levels of Ableist Microaggressions and False Self indicated higher Well-Being, 95% CI [.0034, .6070]). Meanwhile, when Disability Identity is high, high levels of Ableist Microaggressions and the False Self predicted lower levels of Well-Being, 95% CI [-.2991, -.0070]. This finding highlights that higher levels of Disability Identity and the False Self do not produce greater well-being outcomes. Instead, the False Self only produces better Well-Being when Disability Identity is low. See Figure 5 for a graph of this interaction using PROCESS.

Summary. These findings provide further context to the False Self as an operationalized measure by combining the Self-Relatedness and Environment-

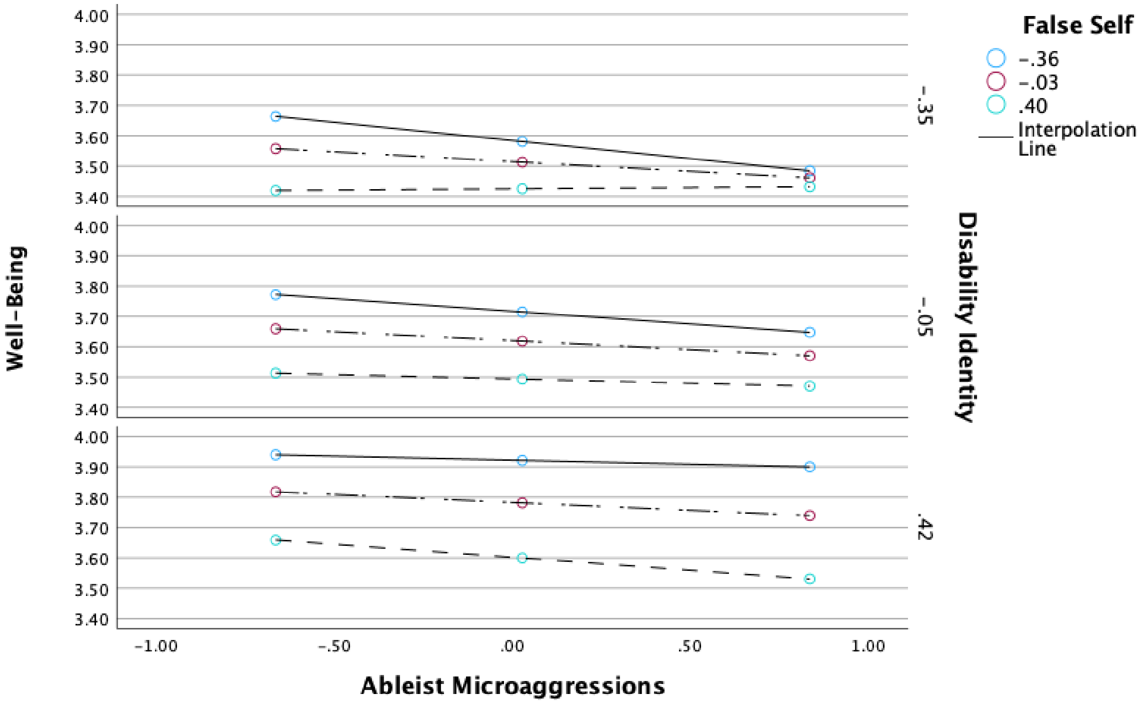
Directedness subscales. Overall, the scale proved to be a reliable measure of the False Self and was normally distributed. The False Self was more closely related to the experience of Immature or Neurotic defenses than Mature Defenses. Additionally, those with greater levels of the False Self tended to have a stronger Disability Identity and be more attuned to recognizing Ableist Microaggressions in their environment.

Assessing the False Self in the main regression model in context with Disability Identity and Ableist Microaggressions on Well-Being provided many interesting findings. Firstly, Ableist Microaggressions alone did not have a significant impact on Well-Being in the context of the model. Meanwhile, Disability Identity showed a positive impact on Well-Being, while False Self had a negative impact. Additionally, none of the two-way interactions were significant.

Results of the three-way interaction indicated that the impact of Ableist Microaggressions and the False Self depended on the level of Disability Identity. Firstly, those with low Disability Identity and greater False Self have better well-being outcomes within a culture of Ableist Microaggressions. This could indicate that the False Self and a disconnection from Disability Identity acts as a buffer to the negative impacts of Ableist Microaggressions. In contrast, in those with a self-reported strong Disability Identity, greater False Self, and recognition of Ableist Microaggressions in their environment actually produced a lower overall Well-Being level. This could indicate that the incongruence of experiencing a strong Disability Identity while grappling with False Self tendencies produce lower levels of Well-Being in those experiencing the impact of frequent Ableist Microaggressions.

Figure 5

Three-Way Interaction Effect of the Exploratory Model



Note. This figure demonstrates the 3-way interaction effect between Ableist Microaggressions (Conover et al., 2017), Disability Identity (Forber-Pratt et al., 2020), and False Self (Eichengreen & Hoofien, 2019) on Well-Being (Ryff & Keyes, 1995). Mean values were centered in the analyses.

Red corresponds to the mean value of Self-Relatedness (-.03), green to one SD below the mean (-.36), and blue to one SD above the mean (.40).

The Impact of Institutional Ableism

Medicaid Satisfaction. To ascertain the role of institutional ableism within governmental disability programs, we explored whether those living with unmet needs from Medicaid home care programs are more likely to experience lower psychological Well-Being. This construct derived from a question asking participants to rank, on a 6-point scale, how satisfied they are with Medicaid services. Results of this linear regression analysis revealed that the model accounted for 5% of the variance in Well-Being and was significant, $F(1,321) = 19.01$, $p < .01$. There was a significant and positive main effect of satisfaction with Medicaid on Well-Being, $\beta = .24$, $t(323)$, $p < .01$. This indicates that the more Medicaid satisfaction a participant experienced, the more likely they exhibit greater levels of Well-Being.

Next, a series of one-way ANOVAs were run to assess whether satisfaction with Medicaid had an impact on any of the other variables. Forty-six participants reported dissatisfaction with Medicaid, 125 participants reported feeling neutrally, and 152 participants reported satisfaction. Firstly, a one-way ANOVA was performed to compare the effect of Medicaid satisfaction on Trust in Healthcare. Results revealed that there was a statistically significant difference in Trust in Healthcare between at least two groups of level of satisfaction with Medicaid, $F(2, 320) = 5.93$, $p < .01$. More specifically, Tukey's HSD Test for multiple comparisons found that the mean value of Trust in Healthcare was significantly less for those who were dissatisfied with Medicaid ($M = 3.07$, $SD = .54$) than those who felt neutrally ($M = 3.28$, $SD = .42$; $p = .36$, 95% CI [-.4108, -.0110]). Trust in Healthcare was also significantly less for those who felt neutrally about Medicaid ($M = 3.28$, $SD = .42$) than those who were satisfied with Medicaid ($M = 3.58$, *SD* = .53; *p* < .01, 95% CI [-.4420, -.1621]). Overall, results indicate that the more satisfaction with Medicaid, the more Trust in Healthcare.

Secondly, a one-way ANOVA was performed to compare the effect of Medicaid satisfaction on Disability Identity. Results revealed that there was a statistically significant difference in well-being between at least two groups of level of satisfaction with Medicaid, *F*(2, 320) = 22.78, *p* < .01. For example, Tukey's HSD Test for multiple comparisons found that the mean value of Disability Identity was significantly less for those that were dissatisfied with Medicaid (*M* = 2.63, *SD* = .34) than those who felt satisfied (*M* = 2.92, *SD* = .42; *p* < .01, 95% CI [-.4369, -.1455]). Additionally, the mean value of Disability Identity was significantly less for those that felt neutrally about Medicaid (*M* = 2.65, *SD* = .30) than those who felt satisfied (*M* = 2.92, *SD* = .42; *p* < .01, 95% CI [-.3753, -.1663]). There was no significant difference in Disability Identity for those who were dissatisfied and those who felt neutrally. Overall, results indicate that those who are satisfied with Medicaid report a stronger Disability Identity.

Thirdly, a one-way ANOVA was performed to compare the effect of Medicaid satisfaction on the False Self. Results revealed that there was a statistically significant difference in Well-Being between at least two groups of level of satisfaction with Medicaid, *F*(2, 320) = 4.76, *p* < .01. More specifically, Tukey's HSD Test for multiple comparisons found that the mean value of False Self was significantly greater for those that were satisfied with Medicaid (*M* = 3.17, *SD* = .44) than those who felt neutrally (*M* = 3.02, *SD* = .37; *p* < .01, 95% CI [-.2609, -.0349]). There were no significant differences in mean levels of the False Self between those who felt satisfied versus dissatisfied with

Medicaid. Overall, satisfaction with Medicaid was associated with greater levels of the False Self compared to those who felt neutrally.

Lastly, a one-way ANOVA was performed to compare the effect of Medicaid satisfaction on Ableist Microaggressions. Results revealed that there was not a statistically significant difference in well-being between at least two groups, $F(2, 320) = 2.72$, $p = .07$). This indicates that satisfaction with Medicaid had no bearing on whether one was more or less attuned to identifying the Ableist Microaggressions in their environment.

Trust in Healthcare. An additional aim of the exploratory analyses was to hone the specific role of Trust in Healthcare, as there are not yet empirically sound ways to measure healthcare discrimination. In a simple correlation, data indicated that those who reported greater Trust in Healthcare also indicated greater levels of Well-Being, $r = .36$, $p < .01$. Looking at Trust in Healthcare in conjunction with other variables, we used a stepwise linear regression model to assess whether high awareness of self-reported experiences of Ableist Microaggressions, low Trust in Healthcare, and low Disability Identity relate to lower levels of Well-Being. Data indicated that the model accounted for 25% of the variance in Well-Being and was significant, $F(3,325) = 36.07$, $p < .01$. There was a significant and negative main effect of Ableist Microaggressions on Well-Being, $\beta = -.35$, $t(328) = -7.15$, $p < .01$. Additionally, there was a significant and positive main effect of Trust in Healthcare on Well-Being, $\beta = .32$, $t(328) = 5.50$, $p < .01$. There was no significant main effect of Disability Identity on well-being in this model, $\beta = .11$, $t(328) = 1.80$, $p = .07$. These findings indicate that, in the context of this model, Ableist Microaggressions indicate lower Well-Being and Trust in Healthcare indicates greater

Well-Being, while Disability Identity alone does not have an impact in the context of the model.

Measuring Medicaid Austerity Ailments. A final aim of the exploratory analyses was to pilot the researcher's Medicaid Austerity Ailments Scale (MAAS) modeled after McGrath's (2016) identified Austerity Ailments. It is a 36-item scale aimed to understand three domains of the psychological impact of an insufficient Medicaid home care system: Instability, Misattunement, and Abuse. Responses are on a Likert-type scale from 1 (*almost never true*) through 7 (*almost always true*). The overall scale has high reliability ($\alpha = .95$), as do the Instability ($\alpha = .78$), Misattunement ($\alpha = .79$), and Abuse ($\alpha = .96$) subscales. The overall MAAS did not display any significant skewedness (-.68) or kurtosis (.56). See Table 10 for further descriptive statistics of the scale, Table 11 for Pearson's correlations between the MAAS and all other variables, and Table 12 for percentages of participant responses to the individual items.

The dearth of research on the impact of institutional ableism in general, but especially in the domain of healthcare, motivated the present analyses. Considering the complex relationship between trust in the system and discrimination, a simple correlation analyses between Trust in Healthcare and the Medicaid Austerity Ailments Scale revealed a small negative relationship ($r = -.20$, $p < .01$). Similar relationships were found between Trust in Healthcare and the Instability subscale ($r = -.45$, $p < .01$), the Misattunement subscale ($r = -.13$, $p < .05$), and the Abuse subscale ($r = -.12$, $p < .05$). This could indicate that the more one feels Medicaid does not fully meet their needs, the less trust they have in the system.

Table 10

Descriptive Statistics of Medicaid Austerity Ailments Scale

Variable	*M*	*SD*	Skew	Kurtosis
Medicaid Austerity Ailments	3.81	.75	-.68	.56
Instability	3.80	.58	-.17	2.82
Misattunement	4.0	.55	-.53	4.50
Abuse	3.74	1.12	-.48	-.31

Note. This table demonstrates descriptive statistics of the researcher-generated Medicaid Austerity Ailments Scale that was normed on the sample of 329 participants.

Table 11

Correlations between Medicaid Austerity Ailments Scale and Other Variables

	MAAS	INST	MIS	AB
False Self [a]	**.39****	.02	**.26****	**.43****
Self-Relatedness	**-.35****	**-.12***	**-.26****	**-.36****
Environment-Directedness	**.33***	-.05	**.22****	**.39****
Ableist Microaggressions [b]	**.64****	**-.29****	**.40****	**.65****
Overall Defensive Functioning [c]	**-.31****	**-.26****	**-.21****	**-.29****
Mature	**-.29****	**-.26****	**-.20****	**-.26****
Neurotic	.08	**.11***	.06	.06
Immature	**.27****	**.21****	**.19****	**.25****
Disability Identity [d]	-.06	**-.31****	.01	.00
Trust In Healthcare [e]	**-.20****	**-.45****	**-.13***	**-.12***
Well-Being [f]	**-.50****	**-.43****	**-.33****	**-.45****
Medicaid Austerity Ailments (MAAS)	---	**.58****	**.73****	**.97****
Instability (INST)	**.58****	---	**.41****	**.40****
Misattunement (MIS)	**.73****	**.52****	---	**.61****
Abuse (AB)	**.97****	**.41****	**.61****	---

Note. This table demonstrates the correlations between the researcher-generated Medicaid Austerity Ailments scale and all other variables utilizing the sample of 329 participants.

[a] Self-Relatedness and Environment-Directedness Scales (Eichengreen & Hoofien, 2019).

[b] Ableist Microaggressions Scale (Conover et al., 2017).

[c] Defense Mechanisms Rating Scale-Self Report (Di Giuseppe et al., 2020).

[d] Disability Identity Development Scale (Forber-Pratt et al., 2020).

[e] Multidimensional Trust in Health Care Systems Scale (Egede & Ellis, 2008).

[f] WB = Well-Being; Scales of Psychological Well-Being—42 items (Ryff & Keyes, 1995).

Table 12

Endorsements of Medicaid Austerity Ailments

Item	Likert-Scale						
	1	2	3	4	5	6	7
<u>Instability</u>							
1. The government threatens cuts to Medicaid funding frequently.	9.7	12.5	22.2	28.9	16.7	7.9	2.1
2. I often worry about my services getting cut.	6.7	7.9	17.0	31.9	21.6	11.6	3.3
3. I feel scared for my future when the government threatens to cut or change Medicaid programs.	5.8	4.9	21.0	21.0	28.0	14.3	5.2
4. I trust the healthcare system for disabled people.	3.3	5.8	13.1	29.5	25.8	15.8	6.7
5. I feel safe relying on Medicaid to sustain my existence.	2.4	6.7	11.2	29.8	25.2	15.5	9.1
6. My case manager has "benefits literacy," meaning that they know how to navigate Medicaid to get me the services I need.	1.8	4.9	15.8	24.0	29.5	17.3	6.7
7. Sometimes I feel like my case manager doesn't have the amount of Medicaid knowledge I would want them to have.	2.4	6.4	22.5	25.8	22.2	13.7	7.0
8. If I got kicked off Medicaid, I would still be okay because I have a stable back-up option.	5.5	12.8	12.8	32.8	20.1	10.6	5.2
9. The access to Medicaid services makes my life feel stable.	3.3	5.2	15.8	29.5	20.7	16.7	8.8
<u>Attunement</u>							
10. The government has a decent understanding of the disabled experience.	2.1	5.8	19.1	27.4	26.1	13.7	5.8
11. Medicaid policies fully respect the authentic disabled experience.	4.0	7.3	15.5	27.1	21.6	16.1	8.5
12. The way the government views disability is not representative of my reality.	2.1	7.0	16.4	29.8	25.2	12.2	7.0
13. I sometimes feel like I have to fit a certain mold of disability to get services.	5.5	5.5	16.4	30.1	23.7	13.4	5.5
14. The assessment process for home care asks the right questions.	2.4	6.7	13.7	26.1	27.4	17.0	6.4
15. I change aspects of myself that I otherwise wouldn't have to just to ensure that I retain services.	3.0	8.5	15.8	29.2	23.4	15.2	4.6
16. I change aspects of my day I otherwise wouldn't have to just to ensure that I retain services.	2.1	7.6	16.1	31.0	22.2	14.9	5.8
17. My nursing assessor doesn't understand my disability.	8.2	14.6	18.5	27.1	17.0	12.2	2.4
<u>Abuse</u>							
18. I sometimes feel abused by the healthcare system.	12.2	11.9	17.9	24.3	19.5	10.9	3.3
19. Medicaid and government disability policies restrict my life.	9.4	14.3	19.1	22.8	24.0	8.5	1.8
20. I feel neglected by the healthcare system.	11.2	14.4	15.2	25.5	21.0	9.4	4.3
21. Sometimes I feel like Medicaid would rather have me in an institution or dead.	13.4	12.2	16.4	26.1	19.1	10.3	2.4

Table 12 (continued).

Item	Likert-Scale						
	1	2	3	4	5	6	7
22. I don't care for my body in the way that I would like to because of the quality of or the lack of services provided.	7.6	12.2	19.1	26.4	19.8	11.9	3.0
23. Many of my needs remain unmet because of insufficient services.	8.8	10.6	16.7	29.8	18.5	11.6	4.0
24. I frequently am prevented from doing tasks of daily living (like showering, toileting, changing clothes, etc.) because of lack of services available to me.	10.6	11.9	22.8	22.8	20.1	9.4	2.4
25. I live in constant stress because I don't get an appropriate amount of services.	7.9	15.2	16.7	28.3	19.1	10.9	1.8
26. I feel as though the government controls my body.	15.2	9.1	19.8	24.3	19.5	8.8	3.3
27. I feel as though the government controls my finances.	13.1	12.2	17.0	27.7	17.0	11.6	1.5
28. I'm scared to speak out against the healthcare system because I have no other options.	11.2	10.9	18.2	26.7	19.1	10.9	2.7
29. The government controls disabled lives to an unhealthy degree.	11.9	13.1	17.3	24.6	20.1	10.3	2.7
30. The issues I face navigating Medicaid is profoundly isolating.	10.9	12.5	19.1	27.1	20.1	7.9	2.1
31. I feel powerless in the face of navigating Medicaid services.	9.7	12.8	14.9	25.5	21.6	11.9	3.6
32. I feel trapped within Medicaid.	12.8	11.9	17.6	25.8	19.5	10.9	1.5
33. Having access to these services is empowering.	6.1	12.2	14.3	26.7	26.1	10.9	3.6
34. Home care evaluations feel humiliating.	10.9	12.5	18.8	21.6	24.3	10.9	0.9
35. The way I get treated in the Medicaid system makes me feel like I have little value in society.	9.7	16.4	15.2	24.3	18.5	11.6	4.3
36. I leave homecare evaluations feeling humiliated or shameful.	12.8	13.4	19.1	22.8	17.9	11.6	2.4

Note. 1 = Not True at All; 2 = Usually Not True; 3 = Rarely; 4 = Occasionally True; 5 = Often True; 6 = Usually; 7 = Almost Always True

Numbers indicate what percentage of the sample of 329 participants endorsed the item at each rate. These items and categories are from the researcher-generated Medicaid Austerity Ailments Scale.

Further exploration of the Medicaid Austerity Ailments Scale revealed that 14% (*n* = 46) were unsatisfied with Medicaid services, 40% of participants (*n* = 125) felt neutrally, and 46% of participants (*n* = 152) were satisfied with services. In order to test whether there were significant differences in satisfaction of Medicaid, a chi-square analysis was run. Results indicated that the distribution of participant satisfaction with Medicaid was not consistent with the theoretical distribution, $\chi^2 = 186.56$; $df = 4$; $p < .01$. This indicates that it was statistically significant that most participants reported feeling satisfied or neutral about their Medicaid services. However, participants still reported wide-ranging dissatisfaction with particular areas of the Medicaid program. For example, 21% of participants (*n* = 71) were unsatisfied with the number of home care hours, 38% (*n* = 125) were unsatisfied with the quality of home care services, 28% (*n* = 92) were unsatisfied with the home care assessment process, 24% (*n* = 79) were unsatisfied with the staff, 17.9% (*n* = 59) were unsatisfied with the Electronic Visit Verification (EVV) technology that home attendants utilize to clock in and out of work, 18.5% (*n* = 61) were unsatisfied with the breadth of services available, and 25.8% (*n* = 85) were unsatisfied with the rules and restrictions of being enrolled in Medicaid. Lastly, 11.2% (*n* = 37) found the Medicaid system complicated to navigate.

Summary. This section aimed to explore institutional ableism by looking into rates of healthcare misattunement and depravity in the current sample. Overall, the researcher-generated Medicaid Austerity Ailments Scale was a reliable measure that should be further validated in future research. Results indicated that the greater trust one has in the healthcare system and the more one believes their Medicaid program satisfies their needs, the greater overall Well-Being they will exhibit. This may explain the discrepancies in previous literature on Trust in Healthcare and disability. Some studies showed that non-elderly adults with chronic conditions or disabilities exhibit greater Trust in Healthcare (Long & Bart, 2007), while others found that people with a self-reported poor health status report greater distrust (Armstrong et al., 2006; Yang et al., 2011). The present study's findings allude to the idea that the quality of the services and whether they meet the individual's needs has a greater impact on Trust in Healthcare than the presence of disability alone.

Furthermore, the degree of satisfaction with Medicaid services had an impact on many other main variables in the sample. For example, more satisfaction with Medicaid indicated greater Well-Being, greater Trust in Healthcare, greater Disability Identity, and greater False Self presentation.

In terms of those who were unsatisfied with Medicaid, the greatest areas of note (>20% of participant endorsement) were the number of hours of home care services they were granted, the quality of such services, the nursing assessment process to determine number of hours or level of disability, and the rules and restrictions of being a Medicaid participant.

Chapter VI

Discussion

The psychological impact of ableism on well-being, as well as the strategies employed to navigate such harsh social environments, remain a critical but understudied area in the field of clinical psychology. To date, there is no other academic research on the psychological well-being of disabled individuals experiencing significant interpersonal ableism while relying on an underfunded, withholding, and neoliberal medical-industrial complex for their survival.

Therefore, the purpose of this study was multifaceted. Firstly, it was to explore the impact of ableism on well-being, both interpersonally and institutionally, and argue its position as a form of social misattunement in the lives of individuals with significant disabilities relying on Medicaid home care programs. Secondly, it was to conceptualize and operationalize the False Self in disabled populations. While previous theorists have argued that the False Self can be an adaptive coping mechanism (much like defenses) to navigating complex social environments (Bojarski & Qayyum, 2018; Watermeyer, 2012), no empirical studies known to the researcher have explored the False Self as a type of defense utilized to navigate extreme marginalization. Thirdly, we explored the contexts under which the False Self could be helpful or harmful to an individual’s well-being, factoring in their experiences of ableism, connection to the disability community, and how integrated their disability was into their identity.

This section will first describe the research’s key findings and potential contributions to psychological research, clinical practice, and public policy. Next, it will review the limitations of the study. Finally, it will suggest directions for future research and conclusions of the present study. Considering the sample of participants were individuals that were enrolled in Medicaid home care programs, the generalizability of the results should be interpreted within this context.

Review of Key Findings

Ableism: From Microaggressions to Governmental Austerity

As expected, the present study found that the experience of significant ableist microaggressions predicts a greater proclivity to the False Self. Before discussing this finding and the role of the False Self in this population, we must first understand the impact of ableism. Holding Watermeyer's (2012) conceptualization of ableism as a form of social misattunement, the present findings explore what it means for an individual to not be *held in the mind of another* (Allen & Fonagy, 2006) in their immediate social circles and larger society. While attunement is defined as the experience of having one's mental states seen, understood, and held in the mind of another person (Allen & Fonagy, 2006; Kernutt, 2007), this takes a particular meaning in the lives of disabled individuals who face consistent social rejection in the form of microaggressions.

Unsurprisingly, ableist microaggressions were endorsed at high rates and generally had a negative impact on well-being, consistent with previous literature (Kattari, 2020). Out of the four categories of microaggressions identified by Conover and colleagues (2017), "being otherized" and "having one's personhood overlooked" appeared to be related to lower levels of well-being, which addresses the need for positive social experiences in maintaining well-being (Chu et al., 2010). In contrast, a disabled individual believing that others in their social environment perceive them as "helpless" was likelier to report better well-being outcomes. To understand this finding, one should consider the archetypal mold of extreme disability that an individual must fit in order to get disability services (Nishida, 2015). One possible explanation for this particular form of ableism being linked to better well-being outcomes is that the public perception of "helplessness" may actually aid in proving disability status, securing healthcare, and getting the accommodations needed to have one's needs met and maintain well-being.

In terms of institutional ableism, most participants reported being satisfied overall with their Medicaid services. However, satisfaction with Medicaid was also associated with greater levels of the False Self compared to those who felt neutrally about their services. Considering the False Self may prevent one from recognizing or vocalizing when they have unmet needs (Kernutt, 2007), this finding calls into question whether the reported rates of satisfaction with Medicaid were accurate. In other words, the individuals reporting Medicaid satisfaction may not truly be getting their needs met through these services, but instead unconsciously downplaying their needs in order to rectify living within a system of misattunement.

Nevertheless, there was still a wide range of reported dissatisfaction with Medicaid services. This included the number of home care hours given, the quality of such services, the assessment process, the staff, the breadth of services available, and the rules and restrictions required to maintain enrollment in Medicaid. The more tenuity, stress, and misattunement an individual feels from their Medicaid program, the less trust they exhibit in the healthcare system, the less overall well-being they experience, and the less strongly they associate with their disability and the larger community.
Unsurprisingly, trust in the healthcare program itself was also related to better well-being

outcomes. These are critical findings for the present study because, although the False Self originates in the caregiver relationship, it is reinforced and validated by broader social experiences in medical, educational, and institutional settings of misattunement and discrimination (Watermeyer, 2012).

Conceptualizing the False Self

The presentation of the False Self overall, as well as its two distinct components, did not align with mature defenses. Recent research has shown that the use of mature defenses has been linked to lower levels of psychological distress (Di Giuseppe et al., 2021) by not distorting conflict or impacting affective experiences, but instead helping integrate affects with cognitions to relieve distress (Vaillant, 1992). However, this may not be the role of the False Self.

Instead, the False Self aligned with presentations of immature or neurotic defenses. While immature defenses shield any awareness of unacceptable ideas, feelings, and actions in order to protect individuals from feeling threatened, neurotic defenses can keep the individual from being aware of all parts of the conflict (feelings, desires, or thoughts) because holding all aspects will engender anxiety (Di Giuseppe & Perry, 2021). Therefore, we can think of the False Self as defensively shielding all or some parts of one’s affective experiences, thoughts, or needs in order to protect the individual from feeling the full impact of consistent social rejection, much like an immature or neurotic defense style.

Self-relatedness presented similarly to both neurotic and immature defenses, while environment-directedness only aligned with immature defenses. This could suggest that the aspects of the False Self about being overly compliant to others, sensitive to others mirroring, and seeking others' approval (Eichengreen & Hoofien, 2017) can defensively shield all aspects of one's true emotions, thoughts, and actions. Meanwhile, the aspect of the False Self about one's internal experiences, self-efficacy, and self-awareness (Eichengreen & Hoofien, 2017) may have more flexibility in the degree to which it shields an individual's true desires from their conscious awareness.

The False Self's Impact on Well-Being

One of the main findings of the present study was how the False Self can act as a defense system to protect one's well-being, but only under specific contexts—much of which was determined by how integrated one's disability was into their sense of self and social circles. In other words, the False Self alone did not protect or harm an individual in the context of profound ableism until one considered the role of the disability identity. This finding may disprove the proposed hypothesis of an "optimal" middle-ground presentation of the False Self. Instead, it highlights the specific contexts in which greater reliance on the False Self can protect an individual's well-being levels within the disability community. Secondly, this finding further explains Watermeyer's (2012) argument that the False Self is not inherently pathological in the disabled individual but could simply be a rather deft response to ableism, and as such, carries a protective nature for these individuals experiencing significant marginalization. While this argument can be true, the findings of the present study provide clarification on exactly when the False Self can be helpful within this large context of ableism, which will be discussed in the following section.

The Role of Disability Identity. In general, having a strong disability identity and connection to the disability community carries a positive impact on an individual's use of Medicaid disability programs. However, the level of disability identity also informs whether or not the False Self aids in maintaining well-being. For example, for those experiencing significant ableism with little connection to the disability identity or the larger disability community, greater levels of the False Self predicted better well-being outcomes. This is a critical finding that pieces together some gaps in our understanding of disability, ableism, and the False Self. Firstly, it calls into question conceptualizations of the False Self as inherently detrimental to well-being by providing specific contexts where that is not necessarily the case. Secondly, this finding allows us to examine Harter and colleagues' (1996) assertion that the False Self is linked to lower levels of social support with a more nuanced interpretation. While it is true that the False Self in their sample was related to less identification with the disability community or social support, it is not necessarily true that the False Self produced this detrimental social isolation. Rather, the False Self may be a way of maintaining psychological equilibrium within a pre-existing social environment of misattunement and isolation.

However, there were contexts where the False Self became less adaptive. For those experiencing significant ableism while carrying a profound connection to the disability identity and community, a strong False Self predicts worse well-being outcomes. The intrapsychic conflict of experiencing a strong sense of one’s disability identity while also grappling with the False Self within this culture of intense ableism predicts more psychological harm to the individual than not. This form of internal conflict is a familiar theme in psychoanalytic conceptualizations of the self. For example, Bromberg (2012) discussed the importance of integrated self-states, or rather, the ability to hold various pieces of ourselves within an overarching coherence. Furthermore, Stern

(2013) wrote of how the dissociated parts of the psyche can lead to a diminished sense of self. Similarly, the experience of having a strong connection to one's disability while also carrying a dissociative stance on truly knowing oneself can be a vehicle for psychological conflict.

Components of the False Self. Of the two subcategories of the False Self as identified by Eichengreen and Hoofien (2017), self-relatedness had more of an impact on the relationships between ableism, disability identity, and well-being than environment-directedness. Surprisingly, the model with environment-directedness as a factor did not produce any significant results, whereas the model with self-relatedness did. This could imply that the impact of the False Self on one's internal sense of being, self-efficacy, and self-awareness may carry significant meaning for how a disabled individual experiences ableism, disability, and well-being, whereas the part of the False Self that impacts one's reaction to factors in their environment may not embody the same profound meaning.

However, the disability identity complicates this dynamic further. In the context of frequent ableism, when one does not experience a strong connection to the disability identity and community while still carrying greater capacity for self-awareness and efficacy, they experience lower levels of well-being. Meanwhile, when one *does* experience a stronger connection to their disability and the community while exhibiting greater levels of self-awareness and efficacy, they have greater well-being outcomes. This further illuminates the psychological conflict that erupts out of experiencing a strong sense of self yet not being able to integrate one's disability into their lives in a full, nuanced, and meaningful capacity.

Implications

The findings of the present study have several important implications. This includes theoretical implications for how the field understands the impact of ableist microaggressions and the False Self, clinical implications for mental health professionals working with the disability community, and public policy implications for the importance of robust access to disability related services and healthcare.

Conceptualizing the False Self as similar to a neurotic or immature defense style highlights not only the adaptive nature of the False Self argued by other theorists (Bojarski & Qayyum, 2018; Watermeyer, 2012), but challenges the view of the False Self as an inherent pathology with detrimental consequences to one's interpersonal life and self-esteem that must be alleviated in order to achieve wellness. While the terms "neurotic" and "immature" may sound pejorative, defenses are healthy in the service of navigating growth and social relationships (Cramer, 1991; Mahler & McDevitt, 1968). They are only pathological if the defenses used are maladaptive to the present situation or in response to a threat that is no longer present (Cramer, 2015), and even as such, there are degrees of functioning outcomes if the immature defense proves to be maladaptive in some capacity (Perry & Cooper, 1989). By understanding the False Self as similar to these types of defenses, we can recognize not only the contexts in which the False Self protects an individual from bombardment of intense and continuous social stressors that threaten their sense of self, safety, and belonging in the world, but also appreciate the strength, adaptability, and self-preservation needed to protect oneself in such a manner and survive in oppressive societies.

Additionally, the present study deepened our understanding of how the False Self, within this culture of ableism, can either protect or harm a disabled individual, depending on their level of disability identity. The False Self producing better well-being outcomes for those individuals experiencing frequent ableism with low disability identity provides a more nuanced understanding of the function of the False Self, and highlights its role as a protective factor for those individuals struggling to integrate their disability identity and gain support from within the community. The False Self alone may not produce well-being outcomes, but instead may aid in well-being when the individual is facing extreme marginalization with little support or connection to their disability.

There are many implications for clinicians working with this population. Conceptualizing the False Self as similar to an immature or neurotic defense style, as well as understanding the contexts in which it can aid in well-being, informs the psychotherapy process. Defenses should not be mindlessly eradicated in therapy, but instead understood as clues to underlying intrapsychic conflicts within the individual (Cramer, 2015; Vaillant, 1994). Much like defenses, ripping away the False Self without a strong foundation will likely engender further psychological suffering (Cramer, 2015). Instead, over time, bearing witness to and guiding the patient in facing the disavowed parts of themselves within a therapeutic relationship of attunement can restore narrative capacity and create a sense of clearer cohesion within the patient's psyche (Holmes, 2011), which in turn can lessen the need for reliance on the False Self.

However, truly understanding where and when the False Self can aid in well-being is crucial for the pacing of the therapeutic process. Whether the client has access to disability services, a healthy support system, loved ones that respect their disability, and access to others within the disability community will be strong indicators of whether alleviating the False Self will prove helpful or not. The group of disabled individuals who do not necessarily need the False Self to maintain well-being (i.e., those with a strong disability identity) can benefit from therapy aimed at alleviation of the False Self. However, any attempt to eradicate or lessen the False Self in a disabled individual experiencing frequent microaggressions without ensuring the individual has a healthy disability identity could be harmful. Instead, psychotherapy aimed at alleviating the False Self could incorporate a model of Disability-Affirmative Therapy (D-AT; Olkin, 2017) that allows the individual to foster the secure relationship with their disability and the community that is needed for survival in an ableist society.

It is worth noting that, regardless of whether the individual has access to psychotherapy, the ableism that produces the need for the False Self in the first place will still ensue. Therefore, the implications of the present study do not only impact theory and clinical practice, but also provide insight into the psychological impact of ableist social environments, governmental policies, and larger social structures. The negative ramifications of an ableist society and a withholding healthcare infrastructure are abounding (Power & Bartlett, 2019; Ryan, 2019). In an ideal world, to end the need for the False Self, we would make a concerted effort as a society to combat all ableist ideology embedded within our social and political systems. Reducing ableist microaggressions and institutional ableism requires a true commitment to justice and equity, as well as a larger restructuring of societal values (Nario-Redmond, 2019). Public policy measures that allow discourse about disability and anti-ableism frameworks to reduce stigma can aid in the reduction of microaggressions on a mass scale. This could include solidifying governmental laws about genuine disability access in public spaces, creating healthcare programs that prioritize care over budgets and profit, and introducing educational materials into the school system about disability to foster conversations at a young age. Furthermore, in terms of institutional ableism, a robust healthcare system that prioritizes long-term care and disability services is only the first step. Since most people will at some point encounter disability should they live long enough, the present research supports the need for a society that is truly able to hold, embrace, and prepare for the nearly inevitable disabled experience.

Limitations

The findings of this study must be interpreted in the context of its limitations. The first limitation relates to the self-selected sampling bias in data collection, as participants were recruited mainly through disability social media platforms and organizations. Therefore, participants were perhaps more likely to resonate with their disability identity since they had already joined platforms or groups specifically aimed at connecting with others of the same social group. Individuals who are not part of these sorts of groups likely have a differing experience of ableist microaggressions and of their identity as a disabled individual, which could have added to the diversity of responses to the study. However, it remains a challenge to reach a population of disabled individuals without specifically sampling in such places. Future studies can explore the possibility of additionally recruiting participants through medical settings, where individuals are getting health care services for disability-related concerns but may not necessarily be connected to the disability identity enough to seek out proximity to the disability community.

Additionally, one critical purpose of the study was to assess the impact of misattunement, depravity, and ableism from the American healthcare system. This was done by examining the experience of disabled individuals participating in Medicaid-funded home care programs, as they are the largest payer of disability services. However, those experiencing the greatest level of discrimination from the healthcare system may in fact be those with significant disabilities that do not have access to such services in the first place. Lack of services could be due to receiving consistent Medicaid application denials due to the government's arbitrary eligibility criteria for healthcare services. There is a strong argument to be made that perhaps these individuals are the ones experiencing the most institutional ableism, yet due to the inclusion criteria, they are missing entirely from the present study.

Additionally, by requiring participants to sit through and complete a lengthy online survey, it is possible that we were excluding those disabled individuals with the lowest levels of well-being. The present study experienced significant attrition, with many participants quitting the survey part way through. It is possible that more vulnerable disabled individuals (with less well-being or less social support) were unable to sit through a lengthy survey. This could similarly limit the generalizability of our findings by not having included a broader range of struggling individuals in the current study. However, we are unable to verify this hypothesis.

In addition, the survey being offered only online implies we are only surveying those disabled individuals with a certain level of means and resources. Those that do not have a smartphone, computer, or internet access would not be able to complete the survey. Those experiencing the greatest level of poverty, which could imply those with lower well-being, were therefore systemically excluded from the present study.

Furthermore, the lack of greater diversity of the present sample calls into question the generalizability of results. With most of the participants identifying as White (73%) or male (70%), we are predominantly reporting the experience of White disabled men. These individuals provide a narrow scope of the disability experience, and results should be interpreted as such. In addition, a large portion of the sample reported engaging in some form of employment. This could imply that these individuals are in the specific Medicaid programs that allow one to work and retain services, which may indicate a certain level of privilege or resources of the participants that may not be reflective of the majority of individuals utilizing Medicaid disability programs.

Lastly, the self-report nature of the study brings about unique limitations to the present research. Winnicott (1960) argued that when the False Self is at its greatest, it is not conscious to the individual. However, a level of self-awareness may be required to positively endorse items on a False Self questionnaire. Therefore, there is an argument to be made that the False Self (especially when at its greatest) is perhaps not a construct that can fully be encapsulated through self-report measures, but instead by the clinical judgments of trained psychologists.

Future Directions

There are several ways for future research to address the limitations and build upon the current study's findings. Firstly, future research should address the diversity of the sample. This includes utilizing different recruitment to gather individuals with wide-ranging presentation of disability identity, race, gender, and Medicaid-enrollment status.

This would allow for a broader distribution of healthcare mistrust and reported unmet needs by including those who were denied such services.

Next, further research should expand on the psychometric properties of the SREDS (Eichengreen & Hoofien, 2019) as a reliable measure of the False Self. Utilizing this measure alongside concurrent clinical interviews could solidify and explore whether self-report style measures can be an accurate measure of this construct.

Thirdly, further research should focus on the experience of ableism in this population. As an example, research should address whether high scores on the Ableist Microaggressions Scale (Conover et al., 2017) are because one is exposed to a greater number of microaggressions throughout their day, or whether the individual has a greater awareness of what behaviors and comments constitute ableism. Additionally, to further expand on the measurement and impact of institutional ableism, the researcher-generated Medicaid Austerity Ailments Scale should be utilized in future studies.

Fourthly, future research should expand on examining the role of the False Self in this population. Considering a significant reason for the development of the False Self is misattuned parental relationships (Winnicott, 1960), further research should address the role of parental relationships in the development of the False Self in this population. This is especially critical given the finding of Eichengreen and colleagues (2016) that the False Self was greater in those whose parents ignored their child’s disability and enrolled them in intensive rehabilitation programs geared toward eradicating or lessening their disabilities.

Lastly, considering the present study found that the False Self was helpful in those that experienced significant ableist microaggressions without a strong disability identity, future research should explore this intersection further. As an example, future research can explore what resources, factors, or supports would be needed to alleviate the False Self while also maintaining well-being for this subset of individuals.

Conclusions

The present study contributed to the literature in many distinct ways. Firstly, it helped us understand a fuller breadth of the detrimental impact of both interpersonal and institutional ableism on well-being. Secondly, it allowed us to explore and de-pathologize the reactions disabled people employ to survive such oppressive experiences, as well as identify the contexts within which these strategies can aid in well-being. Thirdly, it bolstered our understanding of not only how to quantify and measure the False Self in empirical research, but also how to conceptualize it as a necessary defense system that helps individuals maintain homeostasis while living within a culture of frequent misattunement and discrimination.

Most significantly, however, the present study expands our understanding of the function of the False Self. It teaches us how simply arguing that the False Self must be eliminated to increase well-being perpetuates harm to the disability community and is, in fact, often incorrect. Much like the aim of working with defenses in psychodynamic psychotherapy, achieving genuine well-being in this population rests in the capacity to identify what exactly the False Self is protecting against in the first place. The False Self develops in order to maintain psychological equilibrium in the lives of individuals experiencing profound social subjugation, rejection, governmental neglect, a lack of integrated disability identity, and a lack of community within disability spaces. We therefore must not put the burden of achieving wellness and freedom from the False Self on the disabled individual alone while neglecting to address the systems that produced the need for this defense in the first place.

This study explores what it truly means to be *seen* in modern society—and how disabled individuals protect themselves, adapt, and survive when being held in the mind of another does not always lead to intimacy, but instead to injustice or harm. True well-being, liberation, and freedom from the False Self in this population may lie in a commitment to a society of true equity and justice for people of all abilities. Yet, until this is possible, healing may rest in the ability to acknowledge, sit with, and integrate the nuanced experiences of disability into one's sense of self while creating meaningful and genuine connections within the disability community. May we find enough strength to show up daily, as authentically and openly as we can, to pave the road of acceptance for generations after us, so that one day, the False Self is no longer needed. In the words of D.W. Winnicott, "The False Self whispers 'this is who you should be,' while the True Self sings 'this is who you are.'"

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Appendices

Appendix A

Model of Defenses as outlined by Di Giuseppe, M., & Perry, J.C. (2021).

Defensive Category	Defense Level	Defense Mechanism
Mature	High adaptive	Affiliation Altruism Anticipation Humor Self-assertion Self-observation Sublimation Suppression
Neurotic	Obsessional	Intellectualization Isolation of affect Undoing
	Neurotic	Displacement Dissociation Reaction formation Repression
Immature	Minor-image distorting	Devaluation Idealization

		Omnipotence
	Disavowal	Denial Projection Rationalization Autistic fantasy
	Major image-distorting	Projective identification Splitting of self-image Splitting of other’s image
	Action	Acting out Help-rejection complaining Passive aggression

Appendix B

Demographics Questionnaire

What is your age:

- ____

Gender Identification:

- Male
- Female
- Transgender male
- Transgender female
- Non-binary

Household status:

- Live with parents/family
- Live with roommates/friends
- Live alone
- Live with significant other (partner, spouse)

Marital Status:

- Single, never married
- Partner but not married
- Married
- Widowed
- Divorced
- Separated

Highest education level:

- Some High School
- GED/High School completed
- Some college (Bachelors or Associates)
- Associates degree
- Bachelor’s degree
- Some Higher Education (certificate program, graduate school, medical school, law school)

- Higher Education degree (certificate program, graduate school, medical school, law school)

Prominent political ideology:

- Liberal
- Conservative
- Independent
- Other: ____
- No prominent political identification

Race:

- White
- Black or African American
- Native American or American Indian
- Asian
- Native Hawaiian or Other Pacific Islander
- Mixed

Ethnicity:

- Hispanic/Latino
- Non-Hispanic/Latino

Employment Status:

- Currently working full time
- Currently working part-time
- Not working right now
- Never worked

Type of work:

- Not currently employed
- Student
- Volunteer work, no income
- Trained professional
- Skilled Labor
- Administrative staff/Management

- Temporary Employee
- Retail
- Other

My disability is (Click more than one, if applicable):

- A hearing or vision disability
- A chronic illness
- A neurological condition
- A physical disability
- A cognitive disability
- A communication disability
- A mental illness
- Other: _____

On a scale of **1 to 5** (1 being Not At All, and 5 being Very Much) **please write in how much you perceive these important figures in your life <u>wish you were not disabled</u>**.

(Please put "0" if not applicable)

- Parents/Guardians: __
- Siblings: __
- Close friends: __
- Partner: __

I currently use (pick one):

- A traditional home care agency that sends me a home health aide
- A consumer directed model where I (possibly with the help of a representative) hire, fire, and schedule my own workers
- I'm not sure

In my opinion, I: (please pick one)

1. Can pass for able bodied
2. Am slightly visibly disabled, depending on the context
3. Am very visibly disabled (use adaptive equipment, have clear physical characteristics of disability, etc.)

Appendix C

Researcher generated Medicaid Austerity Ailments Scale (MAAS)

Write in how many **hours of Medicaid-funded home care** <u>**per week**</u> **you currently receive. ____**

Write in how many **hours of Medicaid-funded home care** <u>**per week**</u> **you** <u>**WISH**</u> **you received**. (If you are currently satisfied with the number of hours, just write the number you currently receive). ___

Please click your level of agreement with the following statements: (1 = Not true at all, 7 = Very True)

<u>Instability</u>

1. The government threatens cuts to Medicaid funding frequently.
2. I often worry about my services getting cut
3. I feel scared for my future when the government threatens to cut or change Medicaid programs
4. I trust the healthcare system for disabled people
5. I feel safe relying on Medicaid to sustain my existence
6. My case manager has "benefits literacy," meaning that they know how to navigate Medicaid to get me the services I need
7. Sometimes I feel like my case manager doesn't have the amount of Medicaid knowledge I would want them to have
8. If I got kicked off Medicaid, I would still be okay because I have a stable back-up option
9. The access to Medicaid services makes my life feel stable

<u>Attunement</u>

10. The government has a decent understanding of the disabled experience
11. Medicaid policies fully respect the authentic disabled experience
12. The way the government views disability is not representative of my reality
13. I sometimes feel like I have to fit a certain mold of disability to get services

14. The assessment process for home care asks the right questions
15. I change aspects of myself that I otherwise wouldn't have to just to ensure that I retain services
16. I change aspects of my day I otherwise wouldn't have to just to ensure that I retain services
17. My nursing assessor doesn't understand my disability

Abuse

18. I sometimes feel abused by the healthcare system
19. Medicaid and government disability policies restrict my life
20. I feel neglected by the healthcare system
21. Sometimes I feel like Medicaid would rather have me in an institution or dead
22. I don't care for my body in the way that I would like to because of the quality of or the lack of services provided
23. Many of my needs remain unmet because of insufficient services
24. I frequently am prevented from doing tasks of daily living (like showering, toileting, changing clothes, etc.) because of lack of services available to me
25. I live in constant stress because I don't get an appropriate amount of services
26. I feel as though the government controls my body
27. I feel as though the government controls my finances
28. I'm scared to speak out against the healthcare system because I have no other options
29. The government controls disabled lives to an unhealthy degree
30. The issues I face navigating Medicaid is profoundly isolating
31. I feel powerless in the face of navigating Medicaid services
32. I feel trapped within Medicaid
33. Having access to these services is empowering
34. Home care evaluations feel humiliating
35. The way I get treated in the Medicaid system makes me feel like I have little value in society
36. I leave homecare evaluations feeling humiliated or shameful

I am satisfied with Medicaid.

- Yes
- No

If no, I am unsatisfied with: (check all that apply)

- The amount of hours I receive
- The quality of my home care

- The assessment process
- The EVV technology we have to use
- Medicaid/Social services staff (nursing assessor, case managers, Medicaid helpline, etc.)
- The rules and restrictions I have to follow (income restrictions, marriage penalties, etc.)
- The breadth services available to me
- I find it complicated to navigate
- Other: _____

The following are a list of optional open-ended questions you are encouraged to respond to describing your experience receiving home care through Medicaid.

1. Please write about your experience with **the home care assessment process**. This can include your nursing assessment, meetings with your case managers, as well as the process of determining your hours and level of need. Please write about what these processes were like and how it impacts your life and/or mood.

2. Please write about your overall experience with **the eligibility criteria and the restrictions or rules one must follow to be enrolled in Medicaid**. This can include how it impacts your daily life and/or how it makes you feel.

3. **What resources do you explore** when you need help navigating ableism? This could include tangible resources or other kinds of support.

4. What do you need to **feel safe** in your Medicaid participation?

5. What gives you **hope in imagining a future for disabled Americans**?

Appendix D

IRB Approval Form

LONG ISLAND UNIVERSITY

NOTICE TO ALL RESEARCHERS:

Please be aware that a protocol violation (e.g., failure to submit a modification for any change) of an IRB approved protocol may result in mandatory remedial education, additional audits, re-consenting subjects, researcher probation, suspension of any research protocol at issue, suspension of additional existing research protocols, invalidation of all research conducted under the research protocol at issue, and further appropriate consequences as determined by the IRB and the Institutional Officer.

TO:
Elizabeth Kudadjie-Gyamfi - Principal
Investigator Lisa Samstag - Faculty Advisor
Nina Bakoyiannis - Student
Investigator Sara Haden - Faculty
Advisor

FROM:	LIU Institutional Review Board
DATE:	June 05, 2022
PROTOCOL TITLE:	The Psychological Impact of Ableism
PROJECT ID NO:	22/05-071
REVIEW TYPE:	Expedited: Category 7
ACTION:	**Approved**

With the receipt of the additional information, your project has been **approved**. Please note the following:

1. Approval for sites other than Long Island University, if any, is given only for those indicated in the original application and from which appropriate letters of approval have been received by the IRB.

2. The project must be conducted as presented in the application. No changes or alterations may be made to study methods, recruitment processes, subject pool, test instruments, consent forms, etc. without prior IRB approval. Revisions and amendments to the research activity must be promptly reported to the IRB for review and approval prior to the commencement of the revised protocol (the only exception is in those situations where changes in the protocol are required to eliminate apparent, immediate hazards to subjects). The IRB must be notified immediately of any unanticipated problems or adverse events affecting risk to subjects.

3. If consent form(s) have been approved for the research activity, only IRB approved, stamped consent forms may be used in the consent process (copy attached if appropriate). Please destroy all previous versions. Make sure to retain a copy of the approved, stamped consent document(s), as it must be submitted to the IRB at the time of submission of your annual renewal. One signed copy of the stamped form must be given to the subject, one must be placed in the subject's file/chart (if appropriate), and the principal investigator must keep one. You are responsible for maintaining signed consent forms for a period of at least three years after study completion.

4. If consent is online, the online form should include language/indication of the IRB approval and expiration date as would be found on a hard copy/paper form.

Verification of Institutional Review Board (IRB)

Approval LIU Protocol ID: 22/05-071

Protocol Title: The Psychological Impact of Ableism

Phone: (516) 299-3591

E-mail: OSP@liu.edu

Appendix E

IRB approved Consent and Debriefing forms.

LONG ISLAND UNIVERSITY

INSTITUTIONAL REVIEW BOARD (IRB)

RESEARCH PARTICIPANT INFORMED CONSENT FORM

Study Title: The Psychological Impact of Ableism in America

Faculty Investigator: **Dr. Elizabeth Kudadjie-Gyamfi**
of the Psychology Department
Long Island University Brooklyn.
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You are being asked to join a research study. Participation in this study is voluntary. Even if you decide to join now, you can change your mind later.

1. **Why is this research being done?**

   This research is being done to help the field of clinical psychology understand the psychological impact of ableism (both interpersonal and institutional) on disabled individuals in America. **People with disabilities that are currently enrolled in a Medicaid funded home care program for at least a year will be eligible for participation.** We anticipate that about 130 people will take part in this study.

2. What will happen if you join this study?

If you agree to be in this study, we will ask you to do the following things:

- Take an online survey that will ask questions about your experiences of ableism and disability, as well as some other personal questions about how you respond to situations, people, and stress.
- If you do need physical help answering the questions, we recommend you ensure that it is an individual you feel comfortable being honest in front of.
- Participation in the study will take approximately 25 minutes.

3. What are the risks or discomforts of the study?

The risks associated with participation in this study are no greater than those encountered in daily life facing experiences of ableism.

Although it is unlikely, if you begin to feel distressed please feel comfortable clicking the "exit" button on the screen at any time. You may get tired or bored when we are asking you questions or you are completing questionnaires. You are not required to respond to every question. You may exit the study at any point.

Although your IP Address will not be stored in the survey results, there is always the possibility of tampering from an outside source when using the Internet for collecting information. While the confidentiality of your responses will be protected once the data is downloaded from the Internet, there is always the possibility of hacking or other security breaches that could threaten the confidentiality of your responses.

Note that Qualtrics has specific privacy policies of their own. You should be aware that these web services may be able to link your responses to your ID in ways that are not bound by this consent form and the data confidentiality procedures used in this study. If you have concerns, you should consult these services directly.

The only identifying information that will be collected will be your email address if you chose to participate in the online raffle upon completion of the survey. Please be assured that the email addresses submitted will be held separately than the survey responses.

4. Are there benefits to being in the study?

While there is no direct benefit to you from being in this study, it is reasonable to expect that this study may benefit society if the results lead to a better understanding of the impact of ableism on the mental health of disabled individuals.

5. What are your options if you do not want to be in the study?

Your participation in this study is entirely voluntary. You choose whether to participate, and may exit the survey at any time. If you decide not to participate, there are no penalties, and you will not lose any benefits to which you would otherwise be entitled.

6. Will it cost you anything to be in this study?

No.

7. Will you be paid if you join this study?

Upon completion of this survey you will have the opportunity to enter a raffle to win $50 Amazon gift card.

8. Can you leave the study early?

a. You can agree to be in the study now and change your mind later, without any penalty or loss of benefits.
b. If you wish to stop, you may exit the survey by clicking the “exit” button to be redirected to the debriefing form. If clicked, data collected up until that point will not be used.

9. How will the confidentiality of your biospecimens and/or data be protected?

Your identity as a participant will remain confidential. Your name will not be included in any forms, questionnaires, etc. Responses will remain on a password protected computer that only the researcher has access to, and for up to five years. Any study records that identify you will be kept confidential to the extent possible by law. The records from your participation may be reviewed by people responsible for making sure that research is done properly, including members of the Long Island University Institutional Review Board and officials from government agencies such as the National Institutes of Health and the Office for Human Research Protections. (All of these people are required to keep your identity confidential.) Otherwise, records that identify you will be available only to people working on the study, unless you give permission for other people to see the records.

10. What other things should you know about this research study?

What is the Institutional Review Board (IRB) and how does it protect you?

This study has been reviewed by an Institutional Review Board (IRB), a group of people that reviews human research studies. The IRB can help you if you have questions about your rights as a research participant or if you have other questions, concerns or complaints about this research study. You may contact the IRB at 516-299-3591

What should you do if you have questions about the study?

Contact the student investigator Nina Bakoyiannis at Nina.Bakoyiannis@my.liu.edu or the faculty investigator Dr. Elizabeth Kudadjie-Gyamfi at Elizabeth.Kudadjie-Gyamfi@liu.edu and (718-246- 6307). If you wish, you may contact the principal investigator by letter. The address is on page one of this consent form. You can also contact the Program Director, Philip Wong at Philip.Wong@liu.edu or (718) 488-1164. If you cannot reach the investigators or wish to talk to someone else, call the IRB office at 516-299-3591.

You can ask questions about this research study now or at any time during the study.

If you have questions about your rights as a research participant or feel that you have not been treated fairly, please call the Institutional Review Board at Long Island University at (516) 299-3591.

11. What does your agreement on this consent form mean?

By marking the “Agree to Participate” box below, you are indicating that you have fully read the above text, **you agree that you have a disability and are a participant in a Medicaid funded home care program**, and have had the opportunity to print the consent form (or ask for a printed copy) and ask questions about the purposes and procedures of this study. If you choose not to participate, please choose the “Decline to Participate” box below.

☐ I agree to participate
☐ I decline to participate

DATE: ___________

IRB Protocol #: 22/05-071
Approval: June 05, 2022
LIU Sponsored Projects

Debriefing/Additional Information
Permission to Use Information Collected in a Research Study
Psychological Impact of Ableism in America

Thank you for taking part in this study. You were told in the beginning that this study was about the impact of ableism. Now that you have completed the survey, we wanted to let you know that we are looking into how both interpersonal and institutional ableism impact well-being, as well as the various psychological strategies that disabled individuals may employ to cope with discrimination. We appreciate your self-reflection, your honesty, and the contribution you have made to the field of clinical psychology.

If you experience a negative reaction to participating in this research, consider engaging in self-care activities that allow you to regain your balance. Should you need to connect with someone, consider the following confidential resources.

- Crisis center resources can be found here: http://www.iasp.info/resources/index.php/Crisis_Centres/
- 1-800-LIFENET is a suicide prevention hotline and a referral service that can help you find a therapist in your area, especially during the evening.
- New York Samaritans: Ph: 212-673-3000
- New York Help Line: Ph: 212-532-2400
- Contact a mental health professional of your choice, at your own expense.

If you would like a copy of the results of the study once it is completed, you may contact Dr. Elizabeth Kudadjie-Gyamfi at Elizabeth.Kudadjie-Gyamfi@liu.edu. Additionally, if you have any concerns or questions, please send these to either the faculty supervisor Elizabeth Kudadjie-Gyamfi directly at elizabeth.kudadjie-gyamfi@liu.edu or the student investigator directly at Nina.Bakoyiannis@my.liu.edu. All data will be used unless you notify us that you no longer would like your data to be utilized.